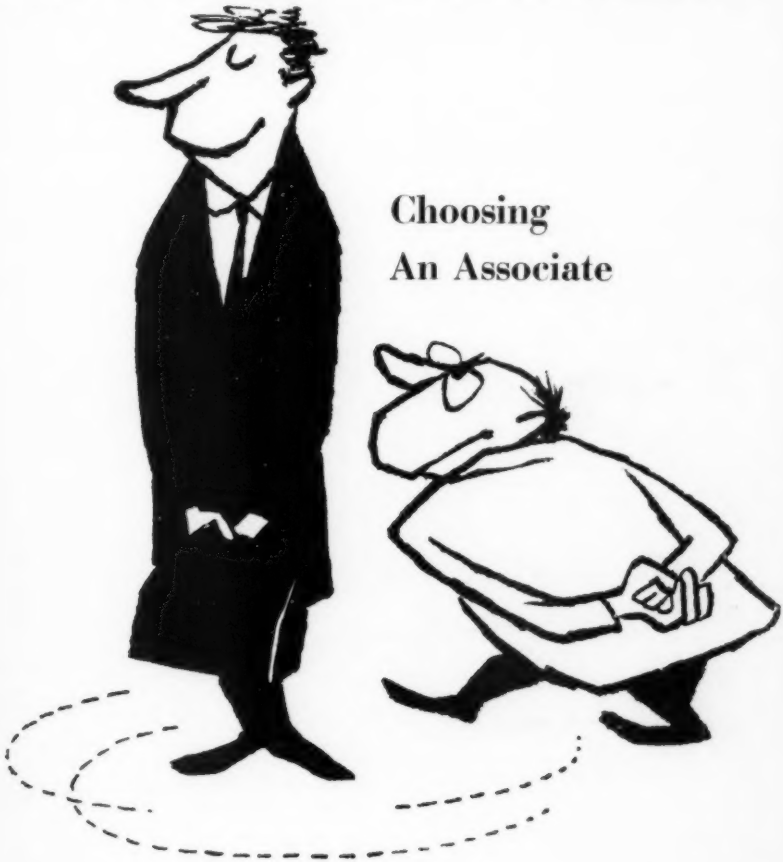
August 1954

Medical Economics



Choosing An Associate

Also in this issue:

- What Doctors Charge
- New Light on Itemizing
- Labor Demands Full Coverage—at Doctors' Expense

in hypertension

Nitranitol
with
Rauwolfia

tandem action for safe, gradual, prolonged relief

Nitranitol for prompt relief of distressing symptoms... slower acting Rauwolfia for prolonged hypotensive and quieting action--no lag in symptom relief. The combination means normal life sooner for your essential hypertensives... no jolting of the vasomotor reflexes... side effects are uncommon.

write: **Nitranitol R.S.** RAUWOLFIA SERPENTINA

for a more normal life sooner for your hypertensive patient

Rx INFORMATION

Nitranitol

SIX DOSAGE FORMS

Nitranitol R.S.
for direct vasodilation plus the added central hypotensive and calming actions of Rauwolfia serpentina
Mannitol hexanitrate . 32 mg.
Rauwolfia serpentina (oleoresin fraction) . 0.5 mg.

Nitranitol
for safe, gradual, prolonged vasodilation
Mannitol hexanitrate . 32 mg.

Nitranitol with Phenobarbital
for the nervous hypertensive
Mannitol hexanitrate . 32 mg.
Phenobarbital . . . . . 16 mg.

Nitranitol with Phenobarbital and Rutin*
for protection in capillary fragility
with Rutin . . . . . 20 mg.

Nitranitol with Phenobarbital and Theophylline*
in threatened cardiac failure
with Theophylline . . 100 mg.

Nitranitol P.V.*
in refractory cases
with alkavervir . . . . . 1 mg.
(alkaloidal fraction of Veratrum viride, standardized for hypotensive activity)

DOSAGE: In blood pressures over 200 systolic, 2 tablets four times daily. In other cases, 1 or 2 tablets every four to six hours. Bottles of 100 and 1,000.

NOTE: Nitranitol is exceptionally stable, assuring uniform potency, so important in medication for your hypertensives.

*Each contains mannitol hexanitrate 32 mg. and phenobarbital 15 mg.

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Since 1828
PIONEER IN MEDICINE FOR OVER 125 YEARS

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August 1954

Medical Economics

MORE ON NEXT PAGE

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DEPARTMENTS

NEWS INDEX

PRICE: 50 cents a copy, $5 a year (Canada and foreign, $6). Acceptance authorized under Section 34.64 PL&R. CIRCULATION: 134,000 physicians and residents. PICTURE CREDITS (left to right, top to bottom): cover, 112, Robert Guidi; 6, Mueller Photo; 7, Herral Long; 9, Wide World; 100-105, American Automobile Association; 110-111, Al Kaufman; 120-122, Walter Daran; 126, Gordon W. Powley, Chase Photo; 127, Akron Beacon Journal; 132-143, Robert McCullough; 154, Vincent A. Finnigan; 205, Blackstone Studios, Walinger.

Panorama

Exposes fee frauds in hospitals • Single-license plan for D.O.s • Virginia Blue Cross faces crisis • Urges fixed-fee schedules for M.D.s • A.C.S. victory in Iowa? • Recent A.M.A. actions

Fee Frauds Exposed

Hospitals that had been illegally appropriating insurance fees earned by their staff physicians were recently exposed in New York (see "Fee Grab by Hospitals," July MEDICAL ECONOMICS). Now the spotlight is shifting to top doctors guilty of the same thing.

In New York City, a special commission appointed by Governor Dewey found that many physicians were pocketing workmen's compensation fees for work they never did. These men, the commission charged, certified to having handled cases that in actual fact they turned over to another doctor—usually a resident or interne.

Now the crackdown has started. Maurice H. Matzkin, the city's deputy hospital commissioner, has instructed municipal hospitals to fire any physician found guilty of such practices. As a result, one hospital has already dismissed a top surgeon and is investigating another.

Meanwhile, the medical societies in that area have sharply reminded their members of the workmen's compensation rules. "The doctor," it is emphasized, "will bill only for such services as he personally rendered or actively and personally supervised."

Good Time for Building

Thinking of building a new office or home? The U.S. Chamber of Commerce says this is a good time to go ahead. Its reasons:

There's a plentiful supply of building materials at steady prices.

Construction labor is working efficiently at fairly stable wage rates.

Interest rates are leveling off and you can get good mortgage terms.

Single-License Plan

Missouri osteopaths, already practicing in six county hospitals, may soon get equal licensure with physicians. The state medical association has recommended the adoption of a single standard for D.O.s and M.D.s;

and the Missouri General Assembly is expected to vote on the measure at its next session.

Says President Harold E. Petersen of the medical society: "One license . . . would set one standard of competence for all physicians in the field of general medical care. In our era of medical advancement, the state has a moral obligation to provide this standard for all its people."

Basically, here's how the doctor-sponsored measure would resolve the issue of cultism vs. medicine:

1. It would set up a single license —that of physician and surgeon. Candidates from schools approved by either the A.M.A. or the American Osteopathic Association would be eligible. They would have to pass a two-part exam in basic science and clinical medicine.

2. Osteopaths already licensed would be authorized to practice medicine and surgery.

3. Medical men would be encouraged to teach in osteopathic schools.

4. Chiropractors already in practice would be permitted to continue, within the framework of existing chiropractic law. But no more would be licensed in the future.

The state's physicians would not be the sole judges of standards, says Dr. Petersen. In fact, he points out, the proposed measure calls for an examining board composed of both D.O.s and M.D.s "in proportion to the numbers of both groups in active practice in this state."

At least one influential osteopath has given his blessing to the proposal. Says Dr. T. T. McGrath, president of the Jackson County Osteopathic Association: "As long as the board is proportionally represented, it's the most logical method of licensing. I'm for it, and I'm certain most other D.O.s are, too."

Prepay Plan in Crisis

The often-heard charge that doctors are wrecking Blue Cross has been raised again, this time in Virginia.

Around the first of the year, the Virginia Hospital Service Association started going into the red at the rate of about $100,000 a month. Citing a spurt of unexpectedly heavy

SINGLE LICENSING STANDARD for Missouri D.O.s and M.D.s is backed by Dr. Harold Petersen.

A RUN ON BLUE CROSS in Virginia is causing the plan to go in the red, says Antone Singsen.

claims as the cause of its plight, the plan asked the State Corporation Commission for an increase in rates.

At the hearing on this request, Antone Singsen, assistant director of the Blue Cross Commission, pointed out why the plan was in trouble:

¶ The proportion of Virginia subscribers admitted to hospitals last year was well above the national Blue Cross average.

¶ The average Virginia subscriber stayed in the hospital at least half a day longer than subscribers to other plans.

¶ The Virginia plan had the highest average hospital stay for maternity cases of any Blue Cross group in the country.

Who was to blame for this run on Blue Cross in Virginia? In some quarters, the doctors were blamed. They hospitalized patients too freely and kept them in too long, it was charged; and thus the plan had been brought to the brink of insolvency.

A premium increase was promptly granted; it went into effect June 1. But the most optimistic estimate is that it will take a year to restore the plan's depleted reserves.

Fixed Fees Urged

Is it high time that doctors stopped varying their fees according to patients' income? One more medical leader—A.M.A. Past President Edward J. McCormick—says so. He has called upon local medical societies to "take the guesswork out of medical costs" by adopting average fee schedules that would apply to "the vast majority of cases" in an area.

In his term-end report before the A.M.A. House of Delegates, the Toledo, Ohio, surgeon cited two main reasons for setting up such schedules:

¶ To establish "appropriate values for professional services" in a given locality, thus eliminating "a large proportion" of complaints from the public;

¶ To enable insurance companies to draw up realistic indemnity schedules, thus letting people know ahead of time how much of their medical bills would be covered by insurance.

What about physicians who con-

sistently levy charges over and above their area's average fees? Dr. McCormick would make short shrift of them: "They should be called before the grievance committees of their local societies to show cause why they should not be suspended or expelled."

An A.C.S. Victory?

"I would like to see Iowa physicians [throw] their books open to inspection . . . so that certified public accountants can make certain they are not engaged in illegal fee splitting."

That statement from Dr. Gerald V. Caughlan, president of the Iowa State Medical Society, may mean that surgeons in his state are ready to bow to the latest edict hurled at them by the American College of Surgeons.

The edict, announced in May, shapes up as one of the boldest moves yet in the crusade against fee splitters. The A.C.S. ordered some 200 Iowa Fellows to submit their books to a C.P.A. audit. Anyone found guilty of fee splitting, said the College, would be expelled, and anyone refusing to submit his books to audit would be expelled or "allowed to resign."

Iowa, of course, has been a hot spot in the fee-splitting controversy since 1952, when the state medical society decided it was ethical for a surgeon and a referring physician to submit a combined bill—provided that the patient had been informed of the agreement. Soon afterwards, the A.C.S. Board of Regents announced that it would not admit new Fellows from Iowa unless an individual candidate could prove "beyond reasonable doubt" that he did not split fees.

FIXED FEE SCHEDULES would "take guesswork out of medical costs," says Dr. E. J. McCormick.

Sum-Up of A.M.A. Actions

In recent weeks, policy-makers of the American Medical Association have taken the following steps:

¶ Labeled as ethical the sending of a joint, itemized statement by two physicians, each of whom has rendered service to a patient—provided that the patient asks for such a joint bill or that an insurance company requires it.

[MORE→

¶ Undertaken (1) "to investigate the relations of physicians to prepaid medical care plans" (such as H.I.P. and Kaiser) and (2) to make (by next June) any interpretation of the code of ethics that may seem necessary in this respect.

¶ Postponed (until December) any action on proposals to effect a closer relationship with osteopaths.

¶ Decided to launch a program of public education, directed against the Veterans Administration practice of determining the service connection of an ailment merely by presumption.

¶ Taken no action on a recommendation that the A.M.A. conduct a poll among U.S. doctors on whether they want Social Security coverage for themselves.

¶ Gone on record (for the first time) as being officially opposed to compulsory (but not voluntary) coverage of physicians under the old-age assistance program of the Social Security Act.

¶ Begun study of a proposal to set up a Federal Department of Civil Defense, equal in status to each of the armed services and with a Secretary of Cabinet rank who would be a member of the Joint Chiefs of Staff.

¶ Discontinued the A.M.A. seal-of-approval program for voluntary health insurance plans and declined, at the same time, to set up a new insurance-policy approval program for the guidance of physicians contemplating the purchase of accident, life, liability, and other contracts.

¶ Urged the Government to meet its military need for doctors in the second quarter of 1955 from the pool of regular draft registrants, without recourse to the doctor-draft law, on the ground that medical men completing interneships next year will be ample in number for the requirements of the military.

¶ Reaffirmed the belief that all medical care of servicemen's dependents should be provided by civilian doctors, except in remote or overseas installations where such civilian care is not available.

¶ Endorsed the program, "A Family Doctor for Every Doctor's Family," sponsored by the American Academy of General Practice and conceived by its late vice president, Dr. Merrill Shaw, who outlined the project shortly after he realized that his own failure to be examined periodically had led to incurable cancer.

¶ Criticized the National Foundation for Infantile Paralysis (without naming it) for its alleged lack of discrimination in the way it distributed its anti-polio vaccine.

¶ Urged automobile manufacturers to equip all new cars with safety belts and other safety features.

¶ Called upon Congress to appropriate funds for a new building to house the Armed Forces Medical Library in Washington.

¶ Promised funds to finance the work of an A.M.A. committee set up last year to do something, if possible, to counter the ill effects of the

rash of anti-medicine articles in magazines and newspapers.

¶ Requested organizations that solicit public funds for improving medical care to set aside a share of those funds for the American Medical Education Foundation.

¶ Conferred citations on Smith, Kline & French Laboratories for its "pioneering use of television in bettering the health of the nation" and on Dr. Nicholas P. Dallis for "the outstanding health educational service he performs as the medical member of the team that creates the Rex Morgan, M.D. comic strip."

¶ Agreed to join four other interested agencies (Red Cross, American Hospital Association, American Association of Blood Banks, and American Society of Clinical Pathologists) in trying to coordinate the various blood programs through a National Blood Foundation.

Put *That* in Your Pipe And Smoke It!

Clearly influenced by their own cancer research, Drs. Cuyler Hammond and Daniel Horn (left and center) say they've quit chain-smoking cigarettes for good and all. Now, as you can see, they're confirmed pipe puffers. Here, they're interviewed on their findings (that cigarette smokers die younger) by Charles S. Cameron, medical director of the American Cancer Society. That's a microphone he's holding—not his customary cigar.

Still More Clinical Research Proving the Value of

Roncovite

in anemia therapy —

The rapidly expanding volume of clinical research continues to prove the effectiveness and safety of Roncovite in the common forms of anemia.* These clinical studies of the effect of cobalt-iron have produced gratifying results in several types of anemia.

AREAS OF CLINICAL STUDY INCLUDE:

- iron deficiency anemia
- anemia in chronic infection
- anemia in pregnancy
- anemia in infants and prematures

Cobalt in therapeutic dosage exerts a specific erythropoietic effect on the bone marrow. Roncovite provides the supplemental iron to meet the need of the resulting accelerated hemoglobin formation.

— *and from 1954 clinical reports*

"We agree with Waltner (1930) and Virdis (1952) that iron should be given together with cobalt to obtain the most satisfactory results."[1]

"Evidence suggests that iron and cobalt provide the most effective hematinic for pregnant women."[2]

"The babies were closely observed daily for ill effects of the medication while at the premature unit and when they returned for check-ups. None of them showed harmful effects despite the large doses."[3]

***Bibliography of 192 references available on request.**

1. Coles, B.L., and James, U.: The Effect of Cobalt and Iron Salts on the Anaemia of Prematurity, Arch. Disease in Childhood *29*:85 (1954).
2. Holly, R.G.: The Value of Iron Therapy in Pregnancy, Journal-Lancet *74*:211 (June) 1954.
3. Quilligan, J. J., Jr.: Effect of a Cobalt-Iron Mixture on the Anemia of Prematurity, Texas St. J. Med. *50*:294 (May) 1954.

Roncovite

The original, clinically proved, cobalt-iron product.

SUPPLIED

RONCOVITE TABLETS

Each enteric coated, red tablet contains:
Cobalt chloride..... 15 mg.
Ferrous sulfate exsiccated....0.2 Gm.

RONCOVITE DROPS

Each 0.6 cc. (10 drops) provides:
Cobalt chloride..... 40 mg.
(Cobalt....9.9 mg.)
Ferrous sulfate..... 75 mg.

DOSAGE

One tablet after each meal and at bedtime; 0.6 cc. (10 drops) in water, milk, fruit or vegetable juice once daily for infants and children.

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In Donnagel 'Robins', the antispasmodic-sedative efficacy of the Donnatal formula . . . plus the adsorbent and detoxifying effects of kaolin and pectin . . . plus the superior antacid-demulcent action of dihydroxy aluminum aminoacetate . . . add up to a *comprehensive* antidiarrheal action, *for all ages, in all seasons.*

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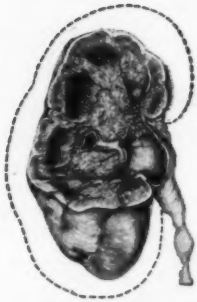
Each 30 cc. of Donnagel (1 fl. oz.) contains:

Antitoxic, Anti-irritant, Antacid	Kaolin (90 gr.)	6.0 Gm.	. . . to adsorb toxins, soothe mucosal irritation, and neutralize any accompanying gastric hyperacidity
	Pectin (2 gr.)	130.0 mg.	
	Dihydroxy aluminum aminoacetate (7½ gr.)	0.5 Gm.	
Antispasmodic-sedative	Hyoscyamine sulfate	0.1037 mg.	. . . to reduce intestinal hypermotility
	Atropine sulfate	0.0194 mg.	
	Hyoscine hydrobromide	0.0065 mg.	
	Phenobarbital (¼ gr.)	16.2 mg.	



RAPID CURES

of urinary tract infections
prevent permanent kidney damage

Infections of the lower urinary tract rarely remain localized for any length of time. The kidneys are often invaded rapidly unless effective treatment is instituted immediately. Hence, the choice of the first drug used may decide the fate of the kidneys.

FURADANTIN®

brand of nitrofurantoin, Eaton

Furadantin is unique, a new chemotherapeutic molecule, neither a sulfonamide nor an antibiotic.

RAPID ACTION. Within 30 minutes after the first Furadantin tablet is taken, the invaders are exposed to antibacterial urinary levels.

WIDE ANTIBACTERIAL RANGE. Furadantin is strikingly effective against a wide range of clinically important gram-negative and gram-positive bacteria, including strains notorious for high resistance.

Scored tablets of 50 mg. Bottles of 50 and 250.

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Also available: Furadantin Pediatric Suspension, containing 5 mg. of Furadantin per cc. Bottle of 4 fl. oz.

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visceral eutonic

DACTIL

PLAIN AND WITH PHENOBARBITAL

relieves **pain⇄spasm** usually in ten minutes

DACTIL relieves gastroduodenal or biliary pain so quickly that you can usually see it work right in your office.

DACTIL capsules act at the site of visceral pain—relieve pain ⇄ spasm within minutes and control spasm within two days. Unusually well tolerated, DACTIL does not interfere with gastrointestinal or biliary secretions, normal tonus or motility.

TWO FORMS *OTD*

DACTIL with Phenobarbital in bottles of 50 capsules. There are 50 mg. of DACTIL and 16 mg. of phenobarbital (warning: may be habit-forming) in each capsule.

DACTIL (plain) in bottles of 50 capsules. There are 50 mg. of DACTIL in each capsule.

DACTIL, first of the Lakeside piperidol derivatives, is the only brand of N-ethyl-3-piperidyl diphenylacetate HCl.

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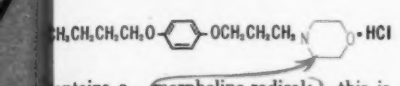
A NEW APPROACH

TRONOTHANE is a new topical anesthetic created by Abbott Laboratories. It fills a conspicuous gap among anesthetics by combining (a) potent relief from surface pain or sensation with (b) relative freedom from sensitization or toxicity.

NOT A "CAINE"

TRONOTHANE is not related structurally to other anesthetics. Its formula



contains a morpholino radical: this is unique among clinically useful local anesthetics, and serves to reduce toxicity in TRONOTHANE. Note the absence, too, of certain familiar chemical groups, as of the "caine" drugs. Thus cross sensitizations are made unlikely.

LESS SENSITIZING

In comparative tests on 69 adults[2]—much more severe than likely in clinical practice TRONOTHANE showed only about one-fifth as many sensitization reactions as another widely used topical anesthetic; what TRONOTHANE reactions did occur were moderate.

PROMPT, EFFECTIVE ACTION

TRONOTHANE's anesthetic excellence is amply demonstrated in clinical tests. For example:

FIELD	No. of cases	Good to excellent results	Per cent good to excellent
PROCTOLOGY[3]	100	92	92
OBSTETRICS[4]	225	200	89
ANESTHESIOLOGY[5]	199	186	93
DERMATOLOGY[1]	185	173	93

Typical uses include relief of discomfort in episiotomy, cracked nipples, hemorrhoids, anal fissure, anogenital pruritus, itching dermatoses, certain intubation procedures, and minor burns or trauma. *Professional literature is available on request from Abbott Laboratories, North Chicago, Illinois.*

Abbott

1. Peal, L., and Karp, M., A New Surface Anesthetic Agent: TRONOTHANE, Anesthesiology, in press, 1954.
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4. Schwartz, F. R., TRONOTHANE in Common Pruritic Syndromes. Postgrad. Med., in press, 1954.
5. Birnberg, C., and Horner, H., A Simple Method for the Relief of Postpartum Perineal Pain, Amer. J. Obst. & Gynec., 67:661, March, 1954.

"TRONOTHANE is an excellent anesthetic agent with minimal sensitivity."[1]

"Quite different from other local anesthetics . . . this may make it a valuable agent for the treatment of individuals who are sensitive to topical agents."[2]

"TRONOTHANE provides a desirable combination of properties—low toxicity, low sensitization, and structural individuality, together with prompt and adequate anesthetic effect."[4]

"Its action was prompt . . . No instance of cross sensitivity to TRONOTHANE was encountered in patients who were reported to be sensitive to other topical anesthetic ointments."[5]

CREAM, 1%, 1 oz. With rectal applicator.

JELLY, 1%, 1 oz. Sterile, with rectal applicator.

COMPOUND LOTION, 1%, 4 fl. oz. Flesh-toned, and resists rubbing off on clothing.

TOPICAL SOLUTION, 1%, 15 cc. Sterile, not for injection.

Sedamyl® gently relieves anxiety and tension generated by social pressure and personal tragedy. Why? Sedamyl is an "unsually safe and practical"[1] non-barbiturate sedative. Patients on Sedamyl stay alert, stay out of the barbiturate fog, avoid the groping travel between hypnosis and hangover. In fact, 9 out of 10 may get smooth yet decisive relief from anxiety and tension[1]... and never experience lethargy or letdown during or after Sedamyl sedation.

sedate with SEDAMYL®

(ACETYLBROMDIETHYLACETYLCARBAMID, SCHENLEY)

relax anxiety, transform tension into a smile

Each Sedamyl tablet provides 0.26 Gm. (4 gr.) acetylbromdiethylacetylcarbamid, Schenley.

1. Tebrock, H. E.: M. Times 79:760, 1951.

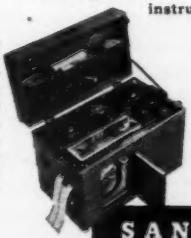
Schenley Laboratories, Inc., *New York 1, New York*

Is there an engineer in the waiting room?

You, as a physician, are thoroughly trained and experienced in detecting the clinical conditions that affect your patients' physical being. They depend on you completely for a knowledge and guidance not possessed by themselves. Conversely, do you not similarly look to professional men in other fields for aid when the need arises?

For example, when there's the question of quality in the consideration of a new piece of diagnostic equipment — such as an electrocardiograph — an engineer can tell better than anyone, sometimes with just a superficial examination, how well the instrument is designed and made. He notices such things as workmanship, the quality of materials, and the grade of the components. As an engineer he would be sure to see the value in unitized construction in the Viso-Cardiette — amplifier, control panel and recorder as three basic assemblies — and the advantages of inkless recording in true rectangular coordinates. He would remark about the minimum of moving parts, the ruggedness of construction, and the precision instrument qualities of the purchased components.

If you are trying to decide which electrocardiograph to buy, we invite this type of comparison between the Viso-Cardiette and any other instrument. To make such an examination of the Viso possible, you may have a Viso for a 15-day* trial without any obligation whatsoever.



* This EXCLUSIVE plan places a Viso-Cardiette in your hands for 15 days. At the end of that trial period, if you are not completely satisfied with the instrument, you simply return it to us and that is all! You're under NO OBLIGATION.

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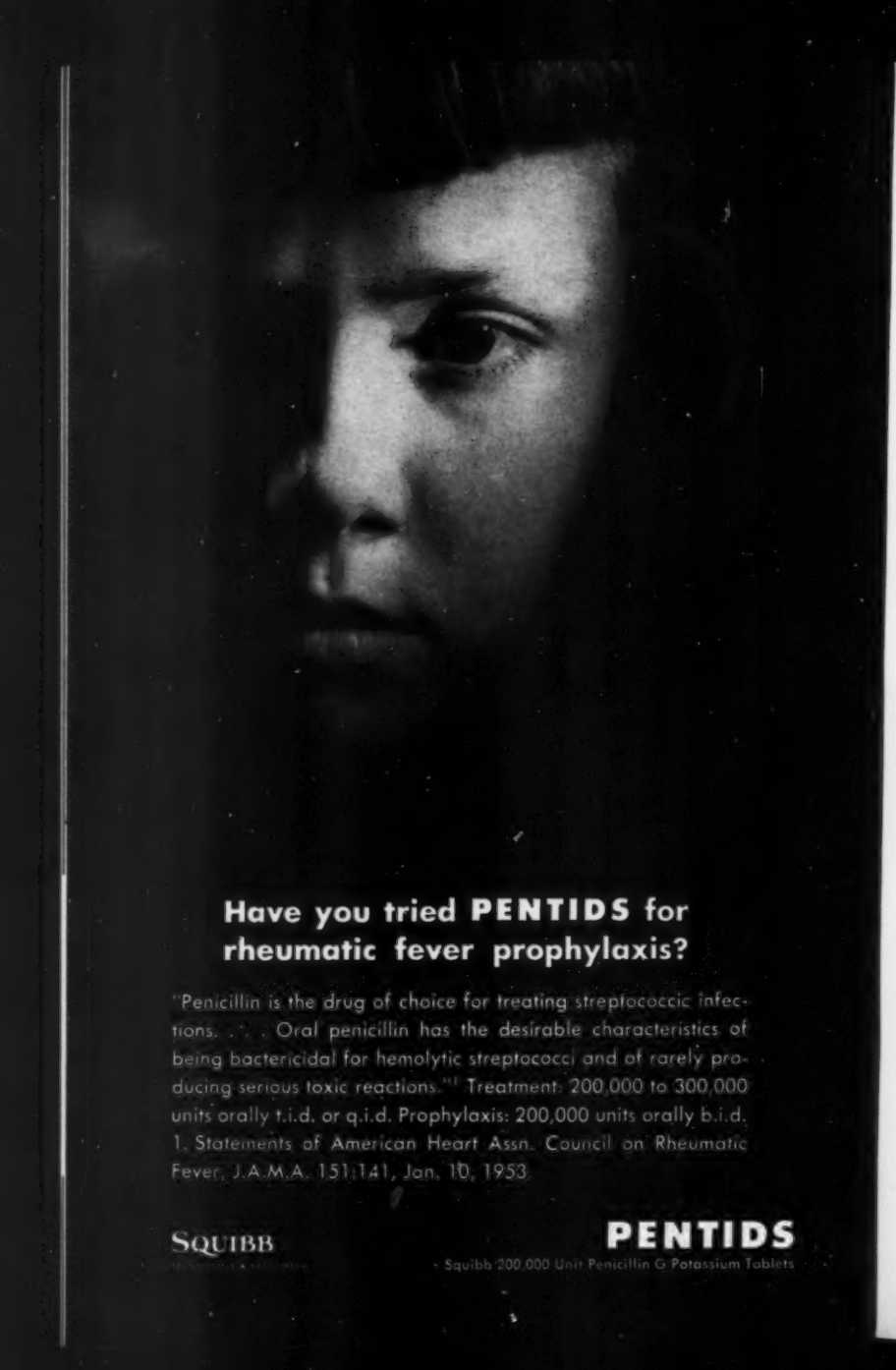
Have you tried PENTIDS for rheumatic fever prophylaxis?
"Penicillin is the drug of choice for treating streptococcic infections. . . . Oral penicillin has the desirable characteristics of being bactericidal for hemolytic streptococci and of rarely producing serious toxic reactions."[1] Treatment: 200,000 to 300,000 units orally t.i.d. or q.i.d. Prophylaxis: 200,000 units orally b.i.d.
1. Statements of American Heart Assn. Council on Rheumatic Fever, J.A.M.A. 151:141, Jan. 10, 1953
SQUIBB
PENTIDS
Squibb 200,000 Unit Penicillin G Potassium Tablets

Rauwidrine™

RAUWIDRINE—a new experience in serenity and pleasant confidence for the depressed and melancholy, the dispirited and frustrated patient.

The contained Rauwiloid not only creates the feeling of serenity but also largely prevents the cardiac pounding, tremulousness and insomnia so often produced by amphetamine alone—and without the use of barbiturates.

In obesity, the appetite-suppressing effect of amphetamine can be maintained for long periods, and the feeling of deprivation is averted.

Rauwidrine combines 1 mg. of Rauwiloid with 5 mg. of amphetamine in one slow-dissolving tablet.

For mood elevation, usual initial dosage, 1 to 2 tablets before breakfast and lunch.

For obesity, 1 or 2 tablets 30 to 60 minutes before each meal.

Physicians are invited to send for clinical test samples.

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HANDICAPS
...OR
REVICAPS?

REVICAPS*

d-Amphetamine—Vitamins and Minerals Lederle

***RE**ducing*
***VI**tamin*
***CAPS**ules*

REVICAPS are an aid in solving the problems of weight reduction. They help the patient to follow a restricted diet. Simultaneously they provide all essential vitamins and minerals.

The methylcellulose content (200 mg.) provides bulk and the inclusion of 5 mg. of d-Amphetamine Sulfate suppresses appetite and elevates the mood of the patient—thereby improving his cooperation.

BOTTLES of 100 capsules available *only on your prescription.*

DOSAGE: One or two capsules, ½ to 1 hour before each meal.

Lederle

LEDERLE LABORATORIES DIVISION
AMERICAN Cyanamid COMPANY
PEARL RIVER, NEW YORK

*REG. U. S. PAT. OFF.

Sidelights

How to protect patients from unnecessary Rx expense • The problem of duplicate form-filling • House calls may be uneconomic, but they provide a rare education • The case of Dr. Washington Irving

Prescription Prices

Should the doctor do anything to enlighten his patients about the prices they can expect to pay for prescriptions he writes? We have long felt that he should—and we note that the A.M.A. now seems to agree. The association's latest public relations pamphlet says this:

"A doctor may not have a real idea of the cost of the items he is prescribing. He can do his patients a real service by checking with local druggists and working up an informal comparative price list on various items. On this basis, he can bring his patients' drug bills down..."

There are two dangers here. One is the danger of recommending a specific pharmacy, which too often suggests collusion between physician and pharmacist. Another is the danger of naming a specific price: If your figure turns out to be low, the patient may later blame both you and the pharmacist.

How to avoid these dangers? Simply find out the price *range* of the most expensive drugs among reputable local druggists, then inform the patient of that range whenever you prescribe such a drug.

This preserves the patient's freedom to choose his own pharmacist; it preserves the pharmacist's freedom to set his own price. At the same time, it gives the patient fair warning if the prescription price quoted is completely out of line.

Carbon Copies

There's no question that the ideal medical office should have carbon copies of all the doctor's prescriptions on file; carbon copies of all his handwritten memos; carbon copies of all his charge slips. It's ideal—but is it practical?

Well, it's not hard to set up such a system; pads with built-in carbons are easily obtainable. It's much harder to instill the carbon-copy habit in the doctor.

Personally, we hate to bother with copies of anything—even letters. Our secretary forces us into some sem-

blance of efficiency on this. But she hasn't been able to push us into filling out *all* forms in duplicate.

For that reason, our current article on charge slips (see "New Light on Itemizing") doesn't mention the use of carbon copies. We're mentioning it here because such use would be ideal. We're also happy to observe that the charge-slip system works without it.

More Office Calls

We've long been advocates of the office call. It's better economics, we maintain—and better medicine, too—to see as many of your patients as possible in your own digs.

Most medical men evidently agree. As you'll see elsewhere in this issue ("How Much Do Doctors Charge?"), there's a trend toward making house-call fees and office-call fees even more disparate than in the past, so as further to discourage needless home visits.

A good idea, we believe.

But we've lately heard such a stirring argument in favor of house calls that we want to share it with you. The speaker is an Eastern G.P., who insists that he *likes* to visit patients in their homes.

"When I stand on the stoop and ring the bell," this doctor says, "I get a sense of expectancy. Anything might be on the other side of that closed door: a crying mother, a raving drunk, a bloody nose, a broken hip, a fear-frozen father, a child with a fever—anything. [MORE→

ON EVERY COUNT... *superior*

superior flavor

Both Poly-Vi-Sol and Tri-Vi-Sol have an exceptionally pleasant "taste-tested" blend of flavors, carefully protected throughout manufacturing. Both infants and children really go for Poly-Vi-Sol and Tri-Vi-Sol. And because all vitamins are synthetic, there's never any unpleasant aftertaste.

superior stability

Mead's years of research in the vitamin field made possible the development of outstandingly stable vitamin solutions. Poly-Vi-Sol® and Tri-Vi-Sol® require no refrigeration and may safely be autoclaved with the formula. And there's no need for expiration dates on the labels.

superior convenience

Both Poly-Vi-Sol and Tri-Vi-Sol are in ready-to-use form. . . . no mixing is necessary. The solutions are light, clear and free-flowing. Sanitary, individually cellophane-wrapped calibrated droppers assure easy, accurate dosage. For infants, drop directly into the mouth. For children, give from a spoon.

VITAMIN SUPPLEMENTS FOR INFANTS

Poly-Vi-Sol

Six essential vitamins for drop dosage

Each 0.6 cc. supplies:

Vitamin A	5000 units
Vitamin D	1000 units
Ascorbic acid	50 mg.
Thiamine	1 mg.
Riboflavin	0.8 mg.
Niacinamide	6 mg.

Tri-Vi-Sol

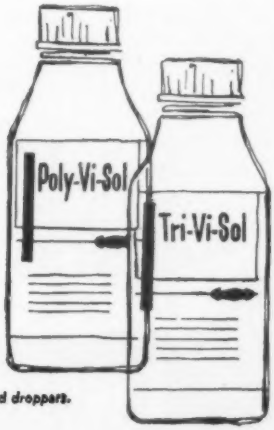
Vitamins A, D and C for drop dosage

Each 0.6 cc. supplies:

Vitamin A	5000 units
Vitamin D	1000 units
Ascorbic acid	50 mg.

superior hypoallergenicity

With all vitamins in synthetic (crystalline) form, and in a completely hypoallergenic solution, Poly-Vi-Sol and Tri-Vi-Sol are well tolerated even by allergic patients.



Available in 15 cc. and economical 50 cc. bottles with calibrated droppers.

MEAD JOHNSON & COMPANY • EVANSVILLE, INDIANA, U. S. A. MEAD

"That's high adventure to start with.

"And then I enjoy those intimate pictures of how our people live, those behind-the-scenes views of life in undress: the dirty housewife and the clean housewife, for instance; or the compulsively neat one and the careless Bohemian.

"And the odors, the curious odors that somehow cling to houses. The sticky bottles of self-prescribed or neighbor-prescribed patent medicines still on the bedside table . . .

"In the homes of my patients, I become the center of the universe for a while. The people look at me in anxiety, in fear, in hope. This is sickness—real sickness. There's nothing like a house call to make the doctor realize the terrible lonesomeness and majesty of his responsibility.

"And the challenge! Anybody can make a diagnosis with a basal metabolism machine and a liver-function testing laboratory handy. But here's a challenge that measures whether, in the field of medicine, you're a man or a boy.

"Can you make an accurate diagnosis with what you have in the bag plus the senses that God gave you and that your medical school sharpened? Can you render skillful treatment without a nurse right there, with the bed too high or too low, with you on the wrong side of it, with no decent sterilizing facilities, and with inadequate light?

"When you handle a house call,

announcing a new th

ACHROMYCIN

Tetracycline Lederle

*RE

new therapeutic advance

At last, the many advantages of intramuscular administration of a broad-spectrum antibiotic have been fully realized. ACHROMYCIN, since its recent introduction, has been notably effective in oral and intravenous dosage forms. Now, after clinical testing, it is definitely proved highly acceptable for intramuscular use.

INTRAMUSCULAR

IMMEDIATE absorption and diffusion
PROMPT CONTROL of infection
CONVENIENT for the physician
NO UNDUE DISCOMFORT for the patient.

This new intramuscular form widely increases the usefulness of ACHROMYCIN, the broad-spectrum antibiotic of choice.

ACHROMYCIN Intramuscular is available in vials of 100 mg.

Lederle
*REG. U.S. PAT. OFF.

LEDERLE LABORATORIES DIVISION
AMERICAN Cyanamid COMPANY Pearl River, New York

you have a foe worthy of you. In your own office or hospital ward, you're a fine technician operating a complex medical machine. But in the patient's home you're no technician. There, you become God's surrogate."

As medical economists, we still favor a higher proportion of office calls. But we do so with every appreciation of the continuing importance of the house call in maintaining patients' health and in building better doctors.

What's in a Name?

When Washington Irving sat down to write a book, he generally datelined it Tarrytown, N.Y. One of his descendants, Dr. Washington M. Irving Jr., has managed things somewhat more dramatically.

Thirty-one-year-old Dr. Irving practices medicine on Irving Boulevard in Irving, Tex. (next door to the Irving Theater). For a while he even had a house on the corner of Irving Boulevard and Irving Heights Drive.

It seems practically inevitable (though it hasn't happened yet) that the doctor will wind up with a son named Irving Irving—or possibly a Quaker daughter-in-law whose married name would be something like Deserving Irving.

But Dr. Irving himself poohpoohs this idea. "My coming to Irving (from plain Crowley, La.)," he says, matter-of-factly, "was pure coincidence." END

S-M-A®

Alphabet of nutrition . . .

Identifying the well-fed baby

Wyeth

Philadelphia 2, Pa.

A. M. A.
ARCHIVES OF
DERMATOLOGY AND SYPHILOLOGY
JUNE 1954
VOLUME 69 NUMBER 6

PANTHODERM
CREAM

first and only topical therapy to contain pantothenyliol

A clean, snow-white,
non-staining,
water-miscible cream.
In 2 oz. and
1 lb. jars; 1 oz. tubes.

samples, detailed literature upon request.

relieves itch and pain

promotes epithelization and healing

Why flavor is important in infant nutrition

Choice fruits and vegetables picked at peak of ripeness are *finer flavored*. When food *tastes* good, Baby thrives *emotionally* as well as physically.

This is why we at Beech-Nut regard *flavor* as vitally important in infant feeding. We choose the very highest quality fresh fruits and vegetables, plump chickens and carefully selected lean meats. All are scientifically processed to retain their tempting flavor, attractive color and *natural* food values in high degree.

The finer flavor and appealing variety of Beech-Nut Strained Foods will keep mealtimes happy for your young patients—help them thrive nutritionally and emotionally from the very start.

A wide variety for you to recommend: Meat and Vegetable Soups, Vegetables, Fruits, Desserts, Cooked Cereal Food, Cooked Oatmeal, Cooked Barley, Cooked Corn Cereal.

All Beech-Nut standards of production and advertising have been accepted by the Council on Foods and Nutrition of the American Medical Association.

BEECH-NUT FOODS FOR BABIES

No. 8 of a series to resolve

SULFA DRUG FACTS

Q. How useful are the Sulfonamides in the treatment of pneumonia?

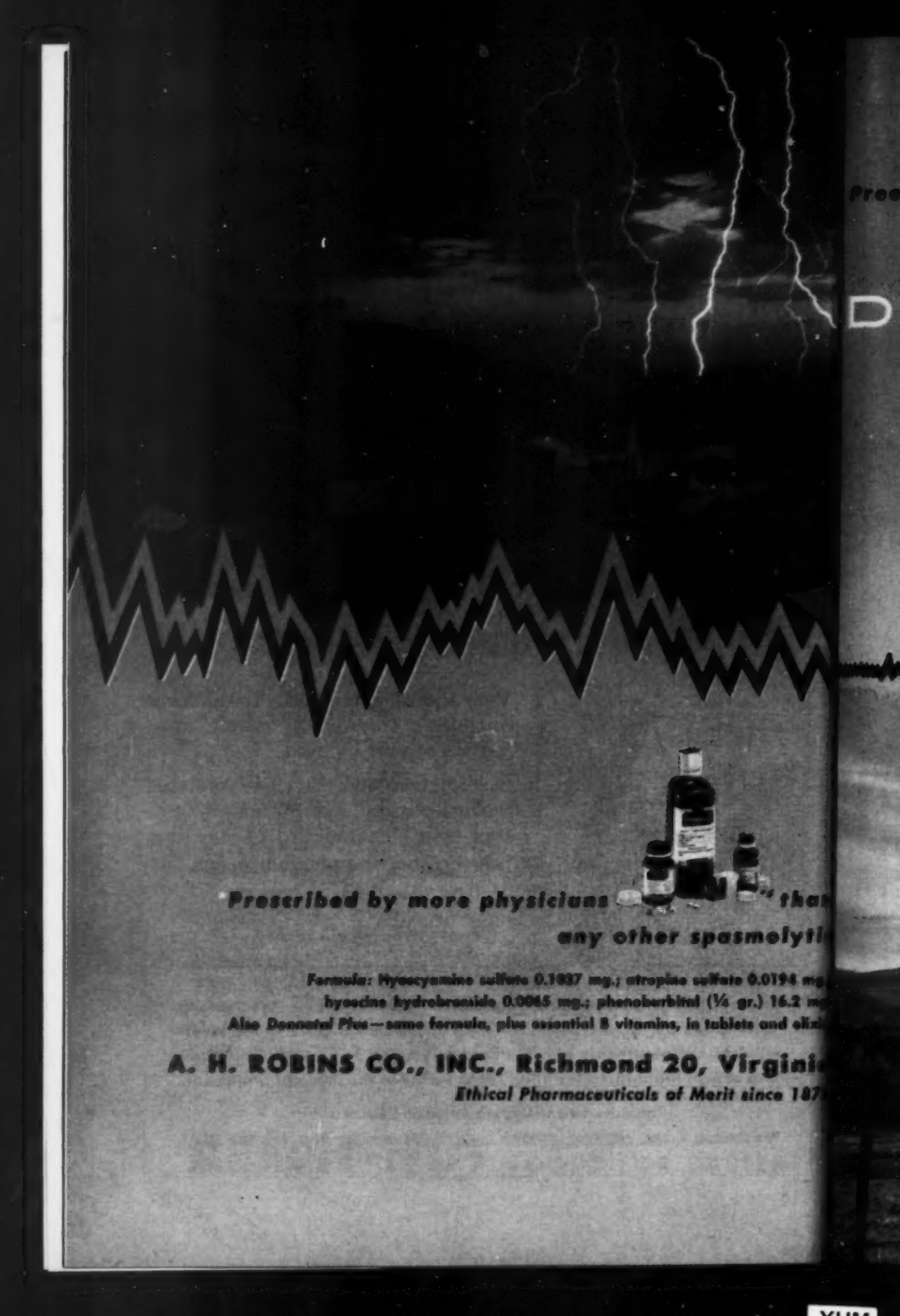
A. Very useful, particularly to reinforce antibiotic therapy or where antibiotics cannot be used.

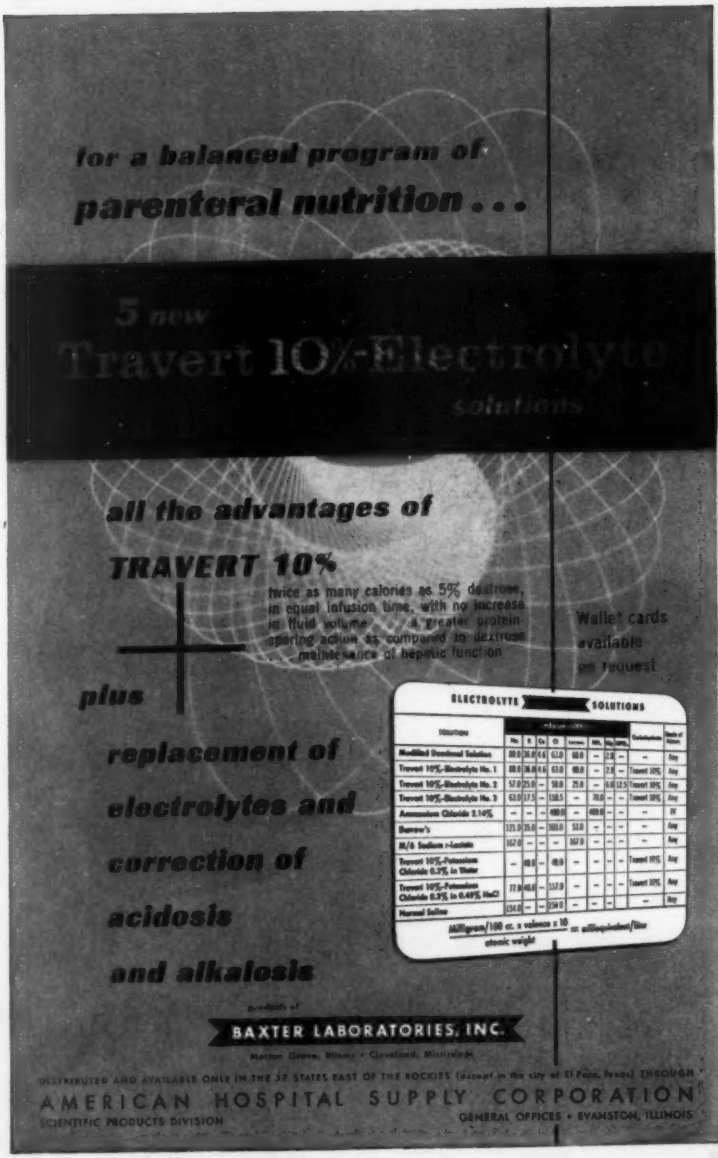
Sulfadiazine and the closely related Sulfamerazine and Sulfamethazine represent the standard of effectiveness against the pneumococcus.

Triple Sulfas (Meth-Dia-Mer Sulfonamides) remain unsurpassed among sulfa drugs for Highest potency • Wide spectrum • Highest blood levels • Safety • Minimal side effects • Economy • This is why leading pharmaceutical manufacturers offer Triple Sulfas to the medical profession.

This advertisement is presented on their behalf by

Fine Chemicals Division, AMERICAN Cyanamid COMPANY, 30 Rockefeller Plaza, New York 20, N.Y.


Prescribed by more physicians
any other spasmolyti
Formula: Hyoscyamine sulfate 0.1037 mg.; atropine sulfate 0.0194 mg.
hyoscine hydrobromide 0.0065 mg.; phenobarbital (¼ gr.) 16.2 mg.
Also Donnatal Plus—same formula, plus essential B vitamins, in tablets and elix
A. H. ROBINS CO., INC., Richmond 20, Virginia
Ethical Pharmaceuticals of Merit since 187


for a balanced program of
parenteral nutrition . . .
5 new
Travert 10%-Electrolyte
solutions
all the advantages of
TRAVERT 10%
twice as many calories as 5% dextrose, in equal infusion time, with no increase in fluid volume . . . A greater protein-sparing action as compared to dextrose . . . maintenance of hepatic function
plus
replacement of electrolytes and correction of acidosis and alkalosis
Wallet cards available on request
ELECTROLYTE SOLUTIONS
Modified Duodenal Solution
Travert 10%-Electrolyte No. 1
Travert 10%-Electrolyte No. 2
Travert 10%-Electrolyte No. 3
Ammonium Chloride 2.14%
Darrow's
M/6 Sodium r-Lactate
Travert 10%-Potassium Chloride 0.3% in Water
Travert 10%-Potassium Chloride 0.3% in 0.45% NaCl
Normal Saline
Milligram/100 cc. x valence x 10 = milliequivalent/liter
atomic weight
products of
BAXTER LABORATORIES, INC.
Morton Grove, Illinois • Cleveland, Mississippi
DISTRIBUTED AND AVAILABLE ONLY IN THE 37 STATES EAST OF THE ROCKIES (except in the city of El Paso, Texas) THROUGH
AMERICAN HOSPITAL SUPPLY CORPORATION
SCIENTIFIC PRODUCTS DIVISION
GENERAL OFFICES • EVANSTON, ILLINOIS

In Seasonal Allergies

Multihist

MULTIPLE ANTIHISTAMINE THERAPY

Full Therapeutic Action with Virtual Freedom from Side Effects

Providing one-third the usual dose of each of three potent antihistamines, one from each major chemical group, Multihist virtually eliminates such troublesome side effects as lethargy, drowsiness, and gastrointestinal upset. Yet it leads to a good therapeutic response in hay fever and in other seasonal and perennial allergies.

Each Multihist capsule contains:

Pyrilamine maleate.....10 mg.
Prophenpyridamine maleate.....10 mg.
Phenyltoloxamine dihydrogen citrate...10 mg.

Multihist exhibits this desirable behavior because each of its ingredients is provided in an amount well below that capable of producing side actions in most patients. Average dose, one capsule three or four times daily. Available also as Multihist Syrup, each teaspoonful (5 cc.) containing one-half the above amounts, in a delightfully palatable syrup vehicle.

SMITH-DORSEY • Lincoln, Nebraska *A Division of* THE WANDER COMPANY

24-HOUR ACTION AGAINST GONORRHEA

AUREOMYCIN* TRIPLE SULFAS is outstanding for use against gonococcal infections. The recommended dose is 2 tablets initially, followed by one tablet at 6-hour intervals for 2 doses. This course may be repeated when necessary.

Each tablet contains:
AUREOMYCIN Chlortetracycline HCl (125 mg.)
Sulfadiazine (167 mg.)
Sulfamerazine (167 mg.)
Sulfamethazine (167 mg.)

Bottles of 12, 100 and 1,000.

Lederle
*TRADE MARK

LEDERLE LABORATORIES DIVISION
AMERICAN Cyanamid COMPANY
PEARL RIVER, NEW YORK

Aureomycin Triple Sulfas

Tablets *Lederle*

for people past forty—

prescribe this potent dietary supplement

MI-CEBRIN

(Vitamin-Mineral Supplements, Lilly)

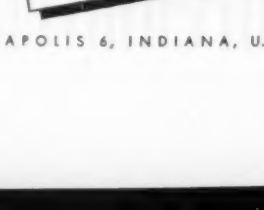
complete — Each Tablet 'Mi-Cebrin' contains 11 vitamins and 10 minerals.

economical — Convenient and economical to take, only one Tablet 'Mi-Cebrin' daily prevents practically all vitamin-mineral deficiencies.

potency protected — A special coating between the vitamins and minerals prevents potency-destroying oxidation-reduction reactions and serves as a moisture barrier for maximum stability.

quality controlled — 'Mi-Cebrin' is painstakingly manufactured. Each lot of 'Mi-Cebrin' undergoes 120 to 130 separate coating operations. Every finished lot is thoroughly assayed before release.

Supplied in bottles of 100 tablets at drug stores everywhere.



ELI LILLY AND COMPANY, INDIANAPOLIS 6, INDIANA, U. S. A.

Letters

Value of office appointments questioned • Insurance doctors tell all • A word of caution on old patient-records • Union man clarifies his position on health insurance • Aide suggests training course for doctors

M.D. Plates Denounced

SIRS: Does the M.D. license plate serve a useful purpose? Do any privileges really go with its ownership?

I'm a careful driver and I observe all traffic regulations. Yet I recently got a ticket for allegedly going through a red light.

For M.D. plates I have just one comment: Nuts!

M.D., New York

SIRS: New Jersey, like half a dozen other states, issues special M.D. plates for physicians' cars. But I, for one, carefully avoid them.

The M.D. tag brings few privileges. About all it *does* assure is (1) that passers-by and policemen will flag you down to give first aid at minor accidents—and will later involve you as a witness; (2) that your car will be a magnet for the drug addict looking for an M.D. bag to pry open; and (3) that you will have a constant lack of privacy.

Believe it or not, I was once importuned by a Good Humor driver to examine him right then and there on U.S. 22, so that he could get his health card renewed in time! The M.D. on my tag was the bait.

Nowadays, I drive incognito.

M.D., New Jersey

'Reinsurance Is Socialism'

SIRS: It should be obvious to all that socialism has no permanent political home and that the present Republican administration has proposed more New Deal socialist legislation than did the preceding Democratic administration. In my opinion, reinsurance is just such a vote-getting scheme.

Carlos E. Fuste Jr., M.D.
Alvin, Tex.

Emergency-Call Help

SIRS: I noticed in my husband's copy of a recent issue of MEDICAL ECONOMICS a complaint that U.S. telephone companies refuse to list medical society emergency call numbers in the front of phone books.

Here on the island of Oahu, the Hawaiian Telephone Company is more cooperative: It donates this

listing on page one of its directory, and also provides a space for the subscriber to write in his family doctor's number.

Betty B. deHay
Lanikai, Hawaii

The Honolulu County Medical Society supplies us with a sample (see cut) from page one of its local phone book. According to the society's executive secretary, the telephone company provides the space "on a public service basis, at our request." —ED.

NAME	PHONE NO.
MY DOCTOR'S NUMBER (If unable to reach your doctor in an emergency, call the Honolulu County Medical Society) →	5-6890
OTHER IMPORTANT NUMBERS IN HONOLULU (For instructions on how to call these numbers from exchanges outside Honolulu, see page 1)	
Board of Water Supply	6-3981
Civil Defense Agency (Territorial)	6-6347
Coast Guard, U.S.	6-3821

No Appointments Here

SIRS: I've just seen an article in MEDICAL ECONOMICS urging doctors not to keep patients waiting in the office. Seems like good advice, doesn't it? But . . .

Many years ago, under the influence of just such an article, I instituted a careful system of appointments in my office. As a result, each patient saw only the persons immediately before and after him. So my patients began to ask, "Where *is* everybody, Doctor? Business slow?"

Now I've abandoned the appointment system, and the minimum wait in my office is about an hour. Yet not a single patient has walked out; and those who comment on the wait seldom complain. Believe it or not, when I *do* offer a patient a special appointment, he often prefers not to tie himself to a definite time, but would rather wait his turn during regular hours.

In my opinion, there's no blanket rule about use or non-use of appointments. It depends on whether or not you're a specialist (I'm not), where you practice, and so on.

Leon Paris, M.D.
Bronx, N.Y.

Insurance Examiners

SIRS: I cannot agree with Dr. John L. Edson's "Misadventures of an Insurance Doctor." In my opinion, our insurance companies have done and are doing a wonderful job.

Dr. Edson maintains that "you do practically all the work in applicants' homes." I have never made an insurance examination in a home, and have never been asked to do so by any company—and I've examined for almost all of them from time to time.

E. A. McGrew, M.D.
Beaver, Okla.

SIRS: For years now, I've refused to make home examinations. But I've let agents know that if an applicant can't see me during office hours, I'll come to my office evenings or weekends, at his convenience. [MORE→

This has apparently suited everyone concerned; and I've been agreeably surprised to find that I'm seldom asked to make these odd-hour examinations.

Paul W. Kniskern, M.D.
Grand Rapids, Mich.

SIRS: In insurance work, as in every other business, the customer is always right. Most applicants want to be given their medical examinations at home. If a doctor is unwilling to do this, he shouldn't get into life insurance work.

M.D., New York

SIRS: My thanks to Dr. Edson for his fine articles. I've actually wept at times over the stupidity of some of the life insurance forms I've had to fill out.

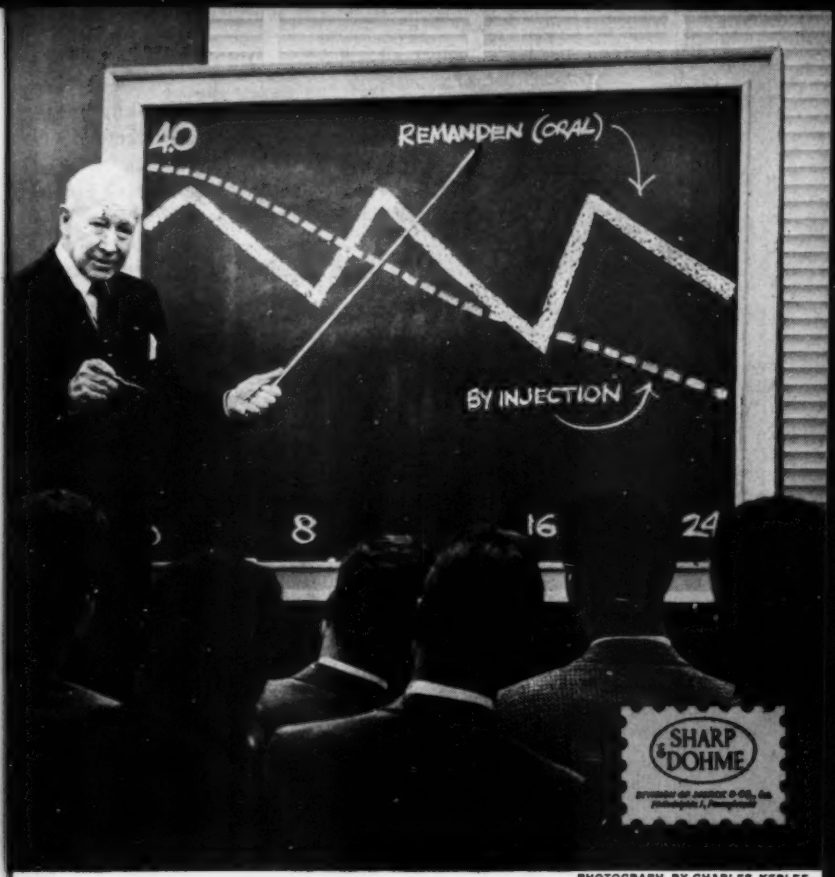
In my younger days, I once examined an unmarried school teacher for an insurance policy. The blank asked: "Was the urine passed in your presence?" To which I wrote this reply: "If you think I'm going to stand by while an unmarried school teacher urinates, you can get another examiner."

Curtis M. Galt, M.D.
Manteca, Calif.

SIRS: I examine for insurance. Your article is plain ridiculous.

James J. Yanick, M.D.
Hornell, N.Y.

SIRS: In forty-four years of practice,



PHOTOGRAPH BY CHARLES KERLEE

Note the sustained penicillin levels with oral

REMANDEN®

PENICILLIN WITH PROBENECID

The probenecid in this oral tablet produces sustained plasma levels comparing favorably with those obtained by intramuscular injections of procaine penicillin.[1] Compared with other oral penicillin preparations, penicillin plasma levels are 2 to 10 times higher.

Quick Information: REMANDEN-100 and REMANDEN-250 supply 0.25 *Gm.* BENEMID® (probenecid) per tablet and 100,000 or 250,000 units of crystalline penicillin G. *Dosage: Adults,* 4 tablets REMANDEN-100 initially, then 2 every 6 to 8 hours. *Children,* usually 2 to 4 tablets daily.

Reference: 1. Antibiotics & Chemotherapy 2:555, 1952.

I've made at least 15,000 insurance examinations for some twenty different companies. Only once or twice in all that time has a company or an agent given me any trouble.

Ray R. Knight, M.D.
Minneapolis, Minn.

SIRS: The forms employed by most insurance companies are practical, concise, and reasonable. The few questions that seem to be of nonmedical importance or in some way redundant actually supply information needed by the company for statistical purposes. And most companies have repeatedly revised and shortened their medical forms, to simplify the examiner's task.

Incidentally, I happen to have been the local examiner (in a city of 100,000) for fourteen life insurance companies since 1925.

M.D., New York

SIRS: In spite of all the questions about urinalysis, it's a rare insurance blank that asks even one question about digital examination of the rectum. I wonder how many big, fat cancers within three inches of the verge have been missed on account of this.

I do rectal examinations anyway, but there's never a place to record the result! How inconsistent can the insurance companies get?

Alton L. Alderman, M.D.
Athena, Ore.

SIRS: Dr. Edson's articles are priceless. I wish he would now suggest a

...There's An Added Performance Factor in LESS-IRRITATING

SEAMLESS PRO-CAP

● As you know, for years a fine woven fabric and a good adhesive compound have been the two basics in the manufacture of premium adhesive plaster. Now Seamless confirms a new quality characteristic—"built-in" freshness.

The long-life adhesive compound used in Seamless Pro-Cap is an exclusive formulation unlike any other used in ordinary plasters. Seamless Pro-Cap is guaranteed fresh. Fresh when you buy it. Fresh when you use it.

Less Irritation with Pro-Cap — The effective action of Zinc Propionate and Zinc Caprylate, has been extended over the longer life span of fresh Seamless Pro-Cap.

FREE Sample—Write Dept. 62 —Prove fresh Seamless Pro-Cap to your complete satisfaction. Use part of the roll now. Put it away for weeks, months. Use it again. You'll know what we mean by "built-in" freshness. Regular or Service Weight.

A Complete Line of Surgical Dressings
U.S.P. Gauze Bandages • Absorbent Cotton • Spool Adhesive Plaster • Sterilized Gauze Pads • Plastic, Elastic and Regular Adhesive Bandages • Plus a complete line of standard hospital items.

PRODUCTS OF PROFESSIONAL DISTINCTION

THE SEAMLESS RUBBER COMPANY

NEW HAVEN 3, CONN., U.S.A.

SEAMLESS

simplified insurance form that could be used by all the companies.

Ralph R. Stevenson, M.D.
Washington, D.C.

Industrial Practice

SIRS: Your recent articles on industrial practice have struck me as valuable and timely. But I regret that you've failed to mention the work of the Occupational Health Institute (formerly the American Foundation of Occupational Health).

This tax-free trust is dedicated to the advancement of medical standards in industry. It runs a certification program for industrial medical departments—and has granted its certificate of approval to 152 of them in the past three years.

Although most of its work has been done with "big business" so far, the Occupational Health Institute is also intensely interested in setting up standards for medical departments in smaller concerns, even those with fewer than 100 employes.

Robert Collier Page, M.D.
Medical Director, Standard Oil Co.
New York, N.Y.

The Occupational Health Institute was founded by the Industrial Medical Association in 1945 "to improve the teaching of industrial medicine . . . and to obtain funds for medical residencies" in this field. In 1950, it also took on the job of evaluating medical services in industry. Medical departments thus far approved

new 3 year study[1] shows

"beneficial effect" of

DESITIN®

OINTMENT

the pioneer external **cod liver oil** therapy

in **extensive dermatitis, diaper rash, severe intertrigo, chafing, irritation** (due to diarrhea, urine, soaked diapers, etc.)

DESITIN OINTMENT achieved "significant amelioration" or practically normal skin in 96¾% of infants and children suffering intense edema, excoriation, blistering, maceration, fissuring, etc. of contact dermatitis. This and other recent studies recommend Desitin Ointment as "safe, harmless, soothing, relatively antibacterial". . . . . protective, drying and healing.[2-4]

Desitin Ointment is a non-irritant, non-sensitizing blend of high grade, crude Norwegian cod liver oil (with its high potency vitamins A and D, to benefit local metabolism,[1] and unsaturated fatty acids in proper ratio for maximum efficacy), zinc oxide, talcum, petrolatum, and lanolin. Does not liquefy at body temperature and is not decomposed or washed away by secretions, exudate, urine or excrements. Dressings easily applied and painlessly removed. Tubes of 1 oz., 2 oz., 4 oz.; 1 lb. jars.

samples and reprint[1] available from

DESITIN CHEMICAL COMPANY

70 Ship Street • Providence 2, R. I.

1. Grayzel, H. G., Helmer, C. B., and Grayzel, R. W.: New York St. J. M. 53:2233, 1953.
2. Helmer, C. B., Grayzel, H. G., and Kramer, B.: Archives of Pediatrics 68:382, 1951.
3. Behrman, H. T., Combes, F. C., Bobroff, A., and Leviticus, R.: Ind. Med. & Surgery. 16:512, 1949.
4. Turell, R.: New York St. J. M. 50:2282, 1950.

include those of such large companies as du Pont, Eastman Kodak, Ford, General Electric, and U.S. Steel.—ED.

Discarding Records

SIRS: In a recent Questions department, you suggested several ways for a doctor to dispose of the records of former patients. One of your recommendations—that the M.D. send postcards to such patients, offering to forward the records to another physician—bothers me.

I know of several men who mailed out just such cards when they went into military service—and thereby incensed a number of patients. Why? Because the patients wanted the records directly.

Furthermore, under some circumstances, the sending out of such postcards might be construed as an opportunistic attempt to recapture patients.

J. P. Revenaugh
Professional Business Management
Chicago, Ill.

Union Editor Speaks

SIRS: In a recent issue you stated that "the A. F. of L. International Association of Machinists has come out with a blanket denunciation of private health insurance."

This isn't true; we haven't condemned *all* such insurance.

Our quarrel, specifically, is with the so-called commercial health and accident policy that can be canceled at any time by the company. We have no complaints about non-can-

How much enjoyment can your geriatric patients get from life?

Of course, with the help of a good well-balanced diet, your older patients can be healthier and more active. That problem of diet is where Gerber's can be of tremendous assistance to you.

First of all, Gerber's variety is wide enough to allow for your patient's "foibles" about food—some of them built up over years and years. Yet that same variety gives you good prescription selectivity.

To help provide both the known and "unknown" nutritive factors, all of Gerber's Strained and Junior (Chopped) Foods are specially processed to retain natural food values to the maximum possible by modern methods.

Added encouragement to staying with your prescribed regimen—Gerber's "Special Diet Recipes." They offer a tempting range of easy-to-make dishes for many tastes. FREE COPIES of this booklet, with recipes based on Bland, Soft, Mechanically Soft, Liquid and Low-Residue Diets. Just write on your letterhead to Dept. 228-4, Fremont, Mich.

Gerber's BABY FOODS

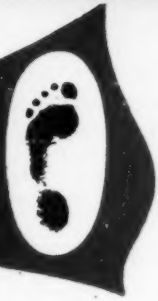
4 CEREALS • 60 STRAINED & JUNIOR MEATS, VEGETABLES, FRUITS, DESSERTS

Your Patients

...especially sensitive to

A recent survey[1] indicates that over 12,000,000 people in the U.S.A. yearly seek professional relief from the distressing symptoms of athlete's foot. Especially sensitive are those who make their living on their feet – all day long – day after day. *These are your patients.* They come to you in greatly increased numbers during these hot summer months when the incidence of crippling athlete's foot is at peak levels.

e to ATHLETE'S FOOT



OCTOFEN® — Preferred Treatment...

SAFE

SIMPLE

OCTOFEN enjoys ready acceptance from the afflicted patient who must stay on the job, on his feet, day in, day out. In most cases, no time is lost — no awkward wet dressings or messy salves needed — just generous and repeated applications of OCTOFEN LIQUID on the affected parts in the office and in the home until relieved. Furthermore, OCTOFEN is non-irritating, greaseless, non-staining, kind to the tender skin, quick drying. For adjuvant treatment and prophylaxis, OCTOFEN POWDER, silk smooth and soothing, may be dusted liberally on the feet, in the socks, for added protection. OCTOFEN POWDER helps keep the feet dry—a must in treatment; curbs foot odors too.

OCTOFEN — True Fungicidal Action

OCTOFEN LIQUID and **POWDER** both contain effective concentrations of 8-hydroxyquinoline, *a true fungicide — death to T. mentagrophytes, arch criminals in athlete's foot.* OCTOFEN LIQUID kills the crippling fungus in 2-minutes flat, in laboratory tests. Clinical studies[2] reveal that this product is effective in over 90% of all cases tried. The most stubborn condition may respond completely in as little as a two week period. Containing moisture-absorbent silica-gel as well as the active fungicide, OCTOFEN POWDER is sound supplementary therapy.

1. MODERN MEDICINE TOPICS, 10:7, 1949 • 2. EXP. MED. & SURG.: 7:37, 1949

McKESSON & ROBBINS
INCORPORATED
Bridgeport 9, Conn.

McKesson & Robbins, Inc., Dept. ME
Bridgeport 9, Conn.

Kindly send me free samples of your OCTOFEN LIQUID and OCTOFEN POWDER.

Name_____ M.D.

Address_____

City_____ Zone____ State_____

celable, guaranteed renewable accident and health insurance.

Gordon H. Cole
Editor, The Machinist
Washington, D.C.

Training the M.D.

SIRS: MEDICAL ECONOMICS often carries articles on how to train an aide. Now how about one on how to train a doctor?

I work for two doctors: full time for an older man with whom I get on very well, and part time for a young specialist who gives me endless trouble.

The younger man tells me to schedule appointments for every fifteen minutes, then keeps his patients waiting an hour or so while he chats with someone else. Then, too, when "my" doctor goes away for a few days, this young man promises to help take care of the practice. Does he? I can practically never find him at all; but if I do, and if I ask him to make a house call, he flatly refuses.

Thank Heaven, I say, for the older "family doctor," not for the specialist.

R.N., Ohio

Covered Artist

SIRS: In the July Memo From the Publisher, you discussed several of your cover artists, including Al Hirschfeld and me. All very well—but you made something of a feature of Mr. Hirschfeld's beard; and you didn't mention my mustache.

I should like to point out that Mr. Hirschfeld's is not the only distinct face in the crowd, as I sport one of the largest mustaches ever raised in my Danish homeland. Since you may not accept this statement at face value (so to speak), I enclose a small self-portrait [*see cut*].

Bodecker (as seen by Bodecker)

The two Danish flags are in honor of the King's birthday (the king, needless to say, is Frederick IX). If you ask me, I'm in the act of singing our national anthem—which, regardless of the fact that the king's name is Frederick, opens with the lines: "King Christian stood by lofty mast, mid fume and smoke . . . "

N. M. Bodecker
New York, N.Y.

END

A VITAMIN-AND-MINERAL-RICH DIETARY SUPPLEMENT

for the bland diet

1 OVALTINE PROVIDES A WEALTH OF ESSENTIAL NUTRIENTS

And in a balanced relationship of protein, vitamins, minerals and other nutrients. See chart below.

2 OVALTINE IS HIGHLY PALATABLE

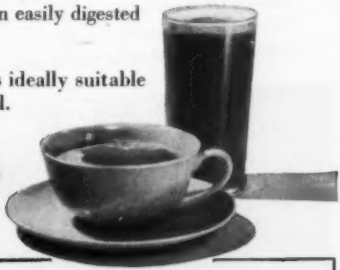
The tempting flavor of this delicious food beverage adds zest to the bland diet. It is taken eagerly even by patients who dislike milk.

3 OVALTINE REDUCES CURD TENSION OF MILK MORE THAN 60%

This dietary supplement is an easily digested addition to the bland diet.

Thus Ovaltine made with milk is ideally suitable whenever a bland diet is required.

Ovaltine is equally delicious served hot or cold.



Ovaltine

The World's Most Popular Fortified Food Beverage

Three Servings of Ovaltine in Milk Recommended for Daily Use Provide the Following Amounts of Nutrients (Each serving made of ½ oz. of Ovaltine and 8 fl. oz. of whole milk)

MINERALS				VITAMINS			
*CALCIUM	1.12 Gm.	MAGNESIUM	120 mg.	*ASCORBIC ACID	37.0 mg.	*THIAMINE	1.2 mg.
CHLORINE	900 mg.	MANGANESE	0.4 mg.	BIOTIN	0.03 mg.	*VITAMIN A	3200 I.U.
COBALT	0.006 mg.	*PHOSPHORUS	940 mg.	CHOLINE	200 mg.	VITAMIN B_{12}	0.005 mg.
*COPPER	0.7 mg.	POTASSIUM	1300 mg.	FOLIC ACID	0.05 mg.	*VITAMIN D	420 I.U.
FLUORINE	0.5 mg.	SODIUM	560 mg.	*NIACIN	6.7 mg.	*CARBOHYDRATE	65 Gm.
*IODINE	0.7 mg.	ZINC	2.6 mg.	PANTOTHENIC ACID	3.0 mg.	*PROTEIN (biologically complete)	32 Gm.
*IRON	12 mg.			PYRIDOXINE	0.6 mg.	*FAT	30 Gm.
				*RIBOFLAVIN	2.0 mg.		

*Nutrients for which daily dietary allowances are recommended by the National Research Council.

THE WANDER CO., 360 N. MICHIGAN AVE., CHICAGO 1, ILL.

For every woman presenting classic menopausal **hot flushes,** there is another who exhibits symptoms which are equally distressing but less clearly defined. For example, insomnia, easy fatigability, **headaches** may also be symptoms of declining ovarian function, but frequently are not so recognized because they occur long before and even years after menstruation ceases. When such is the case, the patient may be expected to **respond** to estrogen therapy. **"Premarin"** (complete equine estrogen-complex) produces not only prompt symptomatic relief but also imparts a gratifying **"sense of well-being."** It has no odor . . . imparts no odor. "Premarin"® estrogenic substances (water-soluble), also known as conjugated estrogens (equine), is supplied in tablet and liquid form.

vitamins for baby

that stay fresh

'Vi-Mix Drops'

(Multiple Vitamin Drops, Lilly)

- **complete**
- **flavorful**
- **potent**
- **stable**

FORMULA—PREPARED AS DIRECTED, EACH 0.6 CC. CONTAINS:

Thiamin Chloride	1 mg.
Riboflavin	1 mg.
Pyridoxine Hydrochloride	0.5 mg.
Pantothenic Acid (as Sodium Pantothenate)	3 mg.
Nicotinamide	10 mg.
Ascorbic Acid	75 mg.
Vitamin B_{12} (Activity Equivalent)	3 mcg.
Vitamin A Synthetic	5,000 U.S.P. units
Vitamin D Synthetic	1,000 U.S.P. units

DOSAGE—Infants under six months, 0.3 cc. daily.
Older than six months, 0.6 cc. daily.

IN 30-CC. AND 60-CC. PACKAGES

ELI LILLY AND COMPANY, INDIANAPOLIS 6, INDIANA, U. S. A.

A New Era in Medicine

CLINICAL ENZYMOLOGY

Parenzyme

Intramuscular trypsin, 5 mg./cc.

NATIONAL

For rapid, dramatic reduction
of acute, local inflammation
regardless of etiology

An Entirely New Type of Therapy...

PARENZYME is Safe. No toxic reactions have been reported following use of this new, INTRAMUSCULAR trypsin.

PARENZYME is Not an Anticoagulant. Anti-inflammatory results do *not* depend on alterations of the clotting mechanism.

PARENZYME Catalyzes a Systemic Proteolytic Enzyme System.

rapidly reduces acute, local inflammation

in *phlebitis, thrombophlebitis, phlebothrombosis*
in *iritis, iridocyclitis, chorioretinitis*
in *traumatic wounds*

PARENZYME has also proved effective in management of varicose and diabetic leg ulcers.

DOSAGE: *Initial Course:* 2.5 to 5 mg. (0.5 cc. to 1 cc.) of PARENZYME (INTRAMUSCULAR trypsin) injected deep intragluteally 1 to 4 times daily for 3 to 8 days. *Maintenance Therapy:* In chronic or recurrent diseases, 2.5 mg. once or twice a week may be required for maximum benefit.

Vials of 5 cc. (5 mg./cc.: crystalline trypsin in sesame oil), by prescription only. *Write for complete information.*

THE NATIONAL DRUG COMPANY *Philadelphia 44, Pa.*

Bulk makes the "Regularity" Diet work!

Rough or gentle, bulk comes from the cellulose of foods plus a liberal fluid intake. Where roughage is needed, your patient may eat foods raw or cooked. In the bland diet, his fruits can be stewed and vegetables puréed.

These are for bulk—

Fruits and vegetables are high in cellulose. And some like oranges, apples, beets, and carrots also provide pectin which absorbs even more fluid to form especially smooth, soothing bulk.

Whole grains not only contain cellulose, but provide vitamin B complex as well.

And lots of liquid to make the cellulose bulky—about 8 to 10 glasses a day. But not all of it has to be water.

Team them up for appetite appeal—

Boiled beets take on new interest when served in a sauce of orange juice combined with sugar, cornstarch, and butter.

Diced apples and dates pair nicely in a salad. Or for dessert, stuff cored apples with dates and bake in orange juice.

Currants, raisins, or cranberries make a tasty surprise in oatmeal muffins.

When your patient learns that these bulk-producing foods can be made appetizing, he's likely to make them a part of his regular diet and so prevent recurrence of his condition.

United States Brewers Foundation

Beer—America's Beverage of Moderation

An 8 oz. glass of beer supplies about 1/8th of the minimum daily requirement of Niacin as well as smaller amounts of other B Complex vitamins.*

If you'd like reprints for your patients, please write United States Brewers Foundation, 535 Fifth Ave., New York 16, N.Y.

*Average of American beers

Announcing the newest (5th) application of S.K.F.'s unique oral dosage form

DEXAMYL

T.M. Reg. U.S. Pat. Off.

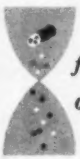
SPANSULE†

BRAND OF SUSTAINED RELEASE CAPSULES

In two dosage strengths:

No. 1—Dexedrine* Sulfate
(dextro-amphetamine sulfate, S.K.F.),
10 mg., and amobarbital, 1 gr.

No. 2—'Dexedrine' Sulfate
(dextro-amphetamine sulfate, S.K.F.),
15 mg., and amobarbital, 1½ gr.



for the continuous and sustained mood-ameliorating effect of 'Dexamyl' over a prolonged period of time

Both dosage strengths are designed to have the same duration of effect. The difference is in the intensity of effect. To determine optimal dosage for an individual, begin with one 'Dexamyl' *Spansule* (No. 2) capsule daily —taken on arising or at breakfast. Response to this dosage will be the best guide to subsequent administration.

made only by
Smith, Kline & French Laboratories · Philadelphia
the originators of sustained release oral medication

†Trademark for S.K.F.'s brand of sustained release capsules (patent applied for).

*T.M. Reg. U.S. Pat. Off. for dextro-amphetamine sulfate, S.K.F.

(see other side)

SPANSULE† *brand of sustained release capsules*

are scientifically and clinically proved, and are made only by S.K.F.— the originators of sustained release oral medication.

15 mg.

Benzedrine* Sulfate Spansule†
amphetamine sulfate, S.K.F.
for day-long relief of psychogenic tiredness

10 mg. & 15 mg.

Dexedrine* Sulfate Spansule†
dextro-amphetamine sulfate, S.K.F.
for day-long control of appetite in weight reduction

No. 1 & No. 2

Dexamyl* Spansule†
a balanced combination of dextro-amphetamine sulfate, S.K.F., and amobarbital
for continuous and sustained mood-ameliorating effect

sustained release of medication over a prolonged period of time

1 gr. & 1½ gr.

Eskabarb* Spansule†
phenobarbital, S.K.F.
for continuous even sedation with phenobarbital throughout the day—or night

8 mg. & 12 mg.

Teldrin* Spansule†
chlorprophenpyridamine maleate, S.K.F.
for continuous and sustained antihistamine effect

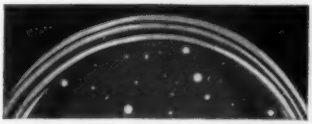
Smith, Kline & French Laboratories • Philadelphia

†Trademark for S.K.F.'s brand of sustained release capsules (patent applied for).
*Trademark

(see other

DIAL SOAP with Hexachlorophene
effects 95% reduction in skin bacteria

Photomicrographs show why



With ordinary soap. Even after thorough washing, thousands of active bacteria remain on the skin.

With Dial soap. Daily use of Dial with Hexachlorophene eliminates up to 95% of resident skin bacteria.

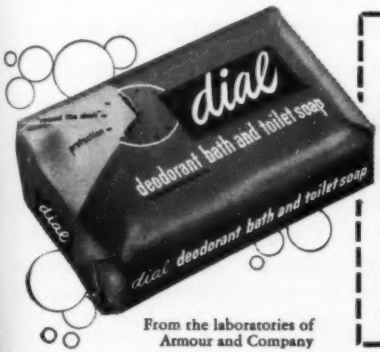
1. *Reduces chance of infection* following skin abrasions and scratches because Dial effectively reduces skin bacteria count.

2. *Stops perspiratory odor* by preventing bacterial decomposition of perspiration, known to be the chief cause of odor.

3. *Protects infants' skin,* helps prevent impetigo, diaper and heat rash, raw buttocks; stops nursery odor of diapers, rubber pants.

4. *Helps skin disorders* by destroying bacteria that often spread and aggravate pimples, surface blemishes.

You know, of course, the remarkable antiseptic qualities of Hexachlorophene soaps, as documented in recent literature. Dial was the first toilet soap to offer Hexachlorophene content to the public. You can safely recommend Dial. Under normal conditions it is non-toxic, non-irritating, non-sensitizing. Furthermore, Dial Soap is economical, and widely available to patients everywhere.



From the laboratories of Armour and Company

Free to Doctors!

As the leading producer of such soaps, we offer you a "Summary of Literature on Hexachlorophene Soaps in the Surgical Scrub." Send for your free copy today.

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why stop **PROTEIN DIGESTION**
to correct **HYPERACIDITY**

Ordinary antacids stop protein digestion, but an *in vivo* study by Tainter* proves that AL-CAROID, by virtue of its "Caroid" content, maintains protein digestion while correcting hyperacidity.

WRITE FOR PROFESSIONAL SAMPLES

AL-CAROID®

antacid-digestant *powder and tablets*

Al-Caroid and Caroid, T. M. Reg.

*Tainter, M. L., et al: Papain, Ann. New York Acad. Sc. 54:143-296 (May) 1951.

AMERICAN FERMENT CO., INC. • 1450 Broadway, New York 18, N. Y.

WHEN YOUR PATIENT MUST "KEEP GOING"

KŪSED

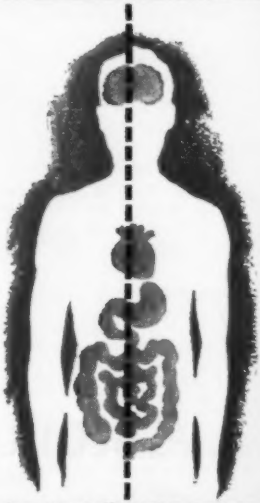
TRADEMARK

provides sedation all along the line . . . with alertness unimpaired

When your patient needs sedation but must face the stresses of daily life, you can provide *comprehensive* sedation plus a psychic release — without clouding of consciousness, gastric disturbance, or drug "hangover" — by writing KŪSED.*

KŪSED acts synergistically at *three important levels* of the nervous system — brain, spinal cord, myoneural junctions — thus permitting effective relaxation without heavy barbiturate dosage.

KŪSED is used widely in anxiety tension; in the control of the tremors and malaise of acute alcoholism; and as a prelude to psychotherapy.



Each KŪSED* capsule contains:

Mephenesin	250	mg.
Calcium Glutamate . .	62.5	mg.
Phenobarbital	7.5	mg.
l-Hyoscyamine HBr . .	0.0625	mg.

DOSAGE: 2 capsules t.i.d. or as indicated, after meals or with milk or fruit juices.

SUPPLIED: Bottles of 100, 500, and 1000 distinctive brown-and-yellow capsules.

Samples and literature on request

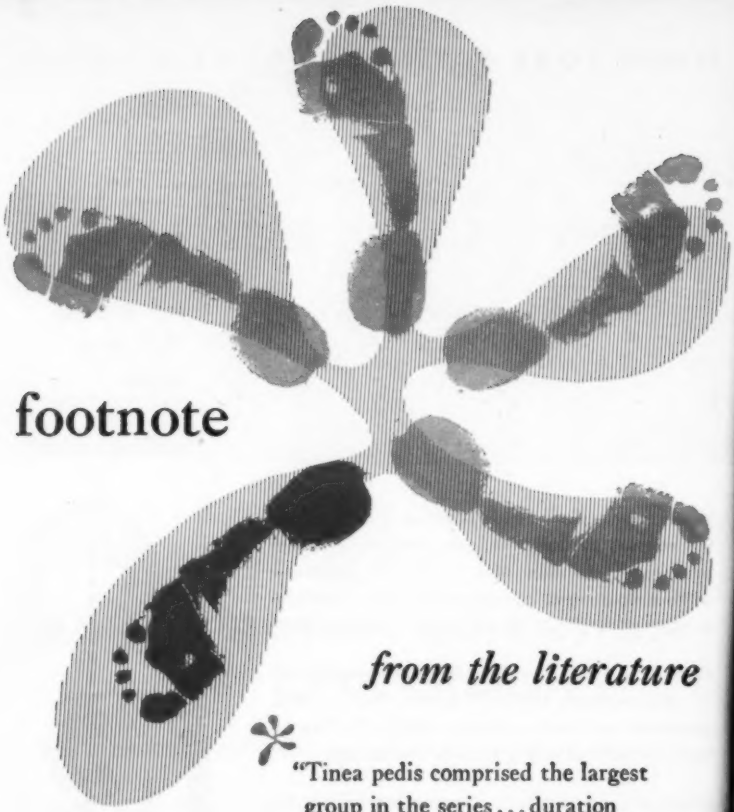
*Trademark of Kremers-Urban Co.

K U

Ethical Pharmaceuticals Since 1894

KREMERS-URBAN COMPANY

LABORATORIES IN MILWAUKEE



footnote

from the literature

"Tinea pedis comprised the largest group in the series... duration of treatment... ranged from one week to two months... in 24 patients the condition healed completely; in 24 it improved strikingly, and in 6 it failed to respond... no adverse reactions from applications of Asterol dihydrochloride were observed."

H. G. Ravits, *J. A. M. A.*, *148*:1005, 19

Asterol

Dihydrochloride

'Roche'

5% tincture
5% ointment
5% powder

Asterol®—brand of diamthazole

HOFFMANN-LA ROCHE INC • ROCHE PARK • NUTLEY 10 • NEW JERSE

whole-root Raudixin:

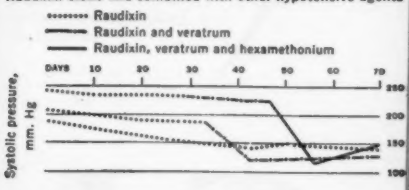
safe, smooth, gradual reduction of blood pressure

Raudixin is the most prescribed of rauwolfia preparations. It is *powdered whole root* of Rauwolfia serpentina—not just one alkaloid, but all of them. Most of the clinical experience with rauwolfia has been with Raudixin.

Raudixin lowers blood pressure in gradual, moderate stages. "A sense of well-being, decrease in irritability, 'improvement in personality' and relief of headache, fatigue and dyspnea" are frequently described by patients.[1]

Raudixin is base-line therapy.
In mild or moderate cases it is usually effective alone; ". . . when rauwolfia is combined with other hypotensive agents, an additive hypotensive effect frequently is observed even in severe hypertension."[2] "It produces no serious side effects. It apparently does not cause tolerance."[1] 50 and 100 mg. tablets, bottles of 100 and 1000.

Raudixin alone and combined with other hypotensive agents



Raudixin Squibb rauwolfia

SQUIBB

1. WILKINS, R. W., AND JUDSON, W. E.: NEW ENGLAND J. MED. 248:48, 195
2. FREIS, E. D.: M. CLIN. NORTH AMERICA 38:363, 1954.

'RAUDIXIN' IS A TRADEMARK

NOW!

The first satisfactory

CLOR

replacement for Chloral and the barbiturates

NOW, FOR THE FIRST TIME, one of the safest and most reliable sedative-hypnotics is available for routine prescription use in a stable, convenient formulation: CLORTRAN capsules chlorobutanol (Wampole).

Beckman[1] remarks, "I think the profession would do well to use this drug more often in insomnia."

PREFERABLE TO THE BARBITURATES because it is not habit-forming and produces refreshing, "normal" sleep from which the patient can be easily and completely roused, CLORTRAN is also *superior to chloral hydrate*, since CLORTRAN does not upset the stomach.[2]

CLORTRAN actually exerts a mildly carminative, soothing, spasmolytic influence on the gastric mucosa and muscularis.[3] Thus, CLORTRAN is specifically and directly beneficial in control of sea-, air-, and car-sickness, nausea and gastritis. Here at last, is a safe, well-tolerated, oral sedative-hypnotic (and antinauseant) that works uniformly well, without "hangover," gastric irritation, or habit-formation.

Dosage: SEDATIVE-ANTISPASMODIC, 0.25 Gm. 2 to 4 times daily.

NAUSEA or MOTION SICKNESS: 0.25 Gm., repeated in 30 minutes if necessary. *Hypnosis:* 0.5-1.0 Gm., ½ to 1 hour before retiring. *Contraindicated* only in severe cardiac, hepatic or renal disease.

CLORTRAN is supplied in golden-orange, soft gelatin capsules, 0.25 Gm. (3¾ Gr.) and 0.5 Gm., STABLE CHLOROBUTANOL (7½ Gr.); bottles of 100.

1. Beckman, H.: *Treatment in General Practice* (Saunders) 1948. 2. Rehfuss, M. E., Albrecht, F. K., and Price, A. H.: *Practical Therapeutics* (Williams & Wilkins) 1948. 3. Krantz, J. C., & Carr, C. J.: *The Pharmacologic Principles of Medical Practice* (Williams & Wilkins) 1951.

CLORTRAN

Sedative-Hypnotic-Antinauseant : Capsules Stable Chlorobutanol (Wampole)

Wampole Laboratories

Henry K. Wampole & Company, Inc., 440 Fairmount Ave., Philadelphia 23, Pa.

SEBORRHEIC DERMATITIS

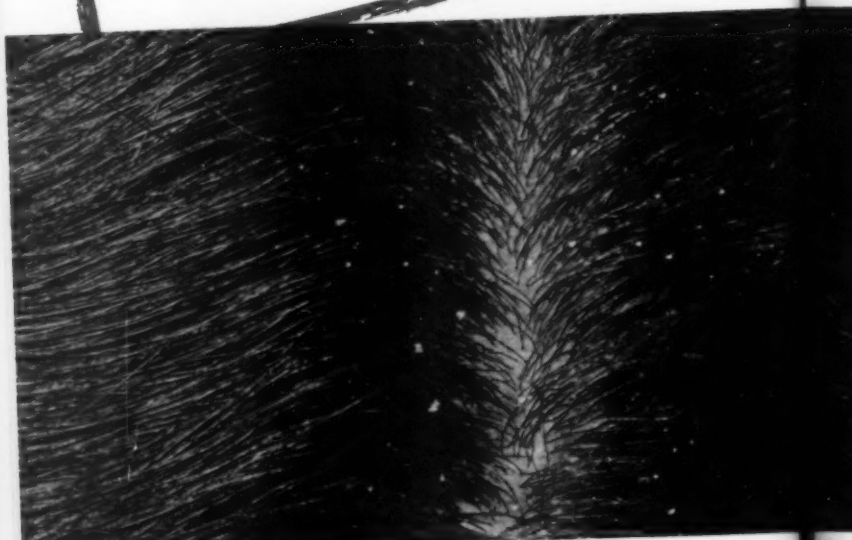
SELSUN®

SULFIDE Suspension*

controls itching and scaling

FOR 1 TO 4 WEEKS

*Selenium Sulfide, Abbott



BEFORE TREATMENT—patient had history of seborrheic dermatitis of the scalp for 13 years. Previous treatment with medicated ointment was unsatisfactory—scaling usually was still evident the next day after washing hair.

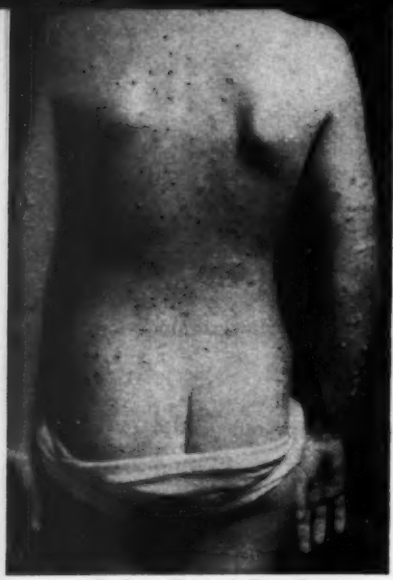
YOU *can expect results like these with* SELSUN: complete control in 81 to 87 per cent of all seborrheic dermatitis cases, and in 92 to 95 per cent of common dandruff cases.[1-3] SELSUN keeps the scalp free of scales for *one to four weeks*—relieves itching and burning after only two or three applications.

Your patients just add SELSUN to their regular hair-washing routine. No messy ointments, no bedtime rituals, no disagreeable odors. SELSUN leaves the hair and scalp clean and easy to manage.

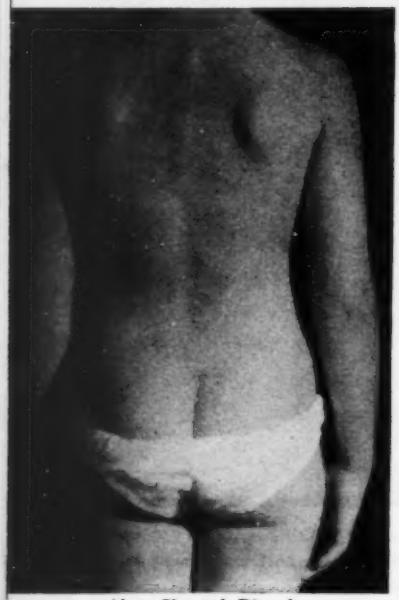
Available in 4-fluidounce bottles, SELSUN is ethically promoted and dispensed only on your prescription. Abbott

1. Slepyan, A. H. (1952) Arch. Dermat. & Syph., 65:228, February.
2. Slinger, W. N. and Hubbard, D. M. (1951) *ibid.*, 64:41, July.
3. Sauer, G. C. (1952) J. Missouri, M. A., 49:911, November.

AFTER TREATMENT—patient applied SELSUN twice a week for first two weeks, once a week for the next two weeks. Then followed a lapse in treatment. Note that scalp is still scale-free two weeks after last treatment.



Before Use of Riasol



After Use of Riasol

If at First You Don't Succeed try, try RIASOL FOR PSORIASIS

In a clinical test on 21 psoriatics who had failed to respond to other drugs, RIASOL cleared the lesions in 38% and improved the condition in 76% of the series. Remissions of psoriasis occur in only 16½% with other kinds of treatment*.

In the successful cases treated with RIASOL, the psoriatic patches faded and cleared in an average of 7.6 weeks. Scaliness was stopped or greatly relieved in 71% of the whole series; redness and papulation, in 67%.

The cutaneous lesions responded to RIASOL regardless of type or location. Results were equally favorable whether the patches were located on the limbs, trunk or scalp. Clearing usually spread from the center toward the periphery of the lesions.

These statistics show why RIASOL should be tried when other treatments fail.

RIASOL contains 0.45% mercury chemically combined with soaps, 0.5% phenol and 0.75% cresol in a washable, non-staining, odorless vehicle.

Apply daily after a mild soap bath and thorough drying. A thin invisible, economical film suffices. No bandages required. After one week, adjust to patient's progress.

RIASOL is supplied in 4 and 8 fld. oz. bottles at pharmacies or direct.

*A statistical study of 231 cases of psoriasis reported by Lane and Crawford in the *Archives of Dermatology and Syphilology* 35:1051, 1937.

**MAIL COUPON TODAY—
TEST RIASOL YOURSELF**

Dept. ME-8-5

**SHIELD LABORATORIES
12850 Mansfield Ave.,
Detroit 27, Mich.**

Please send me professional literature and generous clinical package of RIASOL.

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Street .....
City .....
Zone .... State .....
Druggist .....
Address .....

RIASOL FOR PSORIASIS

invitation to asthma?

not necessarily . . .

Tedral, taken at the first sign of attack, often forestalls severe symptoms.

relief in minutes . . . Tedral brings symptomatic relief in a matter of minutes. Breathing becomes easier as Tedral relaxes smooth muscle, reduces tissue edema, provides mild sedation.

for 4 full hours . . . Tedral maintains more normal respiration for a sustained period—not just a momentary pause in the attack.

Tedral provides:

Theophylline	2 gr.
Ephedrine HCl	⅜ gr.
Phenobarbital	⅛ gr.

in boxes of 24, 120 and 1000 tablets

Tedral®

WARNER-CHILCOTT

Laboratories NEW YORK

Children find Mulcin so delicious that they're always eager for more. Good-tasting Mulcin supplies well balanced amounts of *all* vitamins for which Recommended Daily Allowances have been established. Tempting Mulcin has all the rich flavor and aroma of real orange juice. There's no need to coax even finicky children to take Mulcin. Free-flowing, easy-to-pour Mulcin does not separate and requires no shaking. For infants, Mulcin mixes easily with formulas or other foods. With Mulcin, refrigeration is unnecessary. Specially safeguarded stability assures the full potency you prescribe.

Each teaspoon of Mulcin supplies:

Vitamin A	3000 units
Vitamin D	1000 units
Ascorbic acid	50 mg.
Thiamine	1 mg.
Riboflavin	1.2 mg.
Niacinamide	8 mg.

In 4 ounce and economical 16 ounce bottles.

Mulcin puts a smile in the vitamin spoon

Mulcin

the orange-flavored multivitamin liquid

MEAD JOHNSON & COMPANY • EVANSVILLE, INDIANA, U.S.A. MEAD

Questions

Unpaid accounts • What percentage of income for office expenses? • Transferring auto insurance after trade-in • Rules for issuing Rx's

Unpaid Accounts

I discovered the other day that I have five months' business on the books. In other words, my accounts receivable total five times my average monthly charges. Is this above normal?

Very likely it is. As far as we know, no national study of the subject has ever been made; but a few months ago, a medical management firm did undertake a limited analysis among some of its own clients.

Of the physicians this firm talked to, some had as little as two months' business on the books and others had as much as eight. The average (both for men in solo practice and for partnerships) worked out to about four months.

But to the firm mentioned, even the four-months figure seemed a bit high: "Any doctor with much more than three months' business on his books," it concluded, "is probably heading for trouble." Reason: Once a bill gets much over 90 days old, the chances of collecting it plummet.

The same limited analysis indicated that about 10 per cent of a doctor's patients are likely to owe him about 50 per cent of his accounts receivable. So just collecting a few big accounts (say, those over $100) will often reduce the number of months' business on the books to a manageable figure.

Office Expenses

To help in working out a local fee schedule, we'd like to know what percentage of the average physician's income is spent for professional expenses. What variation is there by specialty?

Just under 40 per cent of the average independent M.D.'s gross income goes into operating expenses —a proportion that has held steady for more than twenty-five years.

In 1928, the average doctor spent $3,500 in running his practice, and this sum was 38 per cent of his gross. By 1951, according to the Seventh MEDICAL ECONOMICS Survey, he paid a whopping $9,500 for expenses, but this was still just 39 per cent of his gross.

Among the major specialties, psy-

chiatrists have the lowest percentage of expenses, and radiologists the highest. Here's the Seventh Survey breakdown:

	% of Gross	*Total Expenses*
Psych./Neuro.	28%	$5,000
Dermatology	34	6,800
Int. Med.	40	7,600
Ophthalmology	37	8,400
Ob./Gyn.	35	8,500
Orthopedics	37	8,800
Surgery	36	9,000
Gen. Pract.	41	9,700
ENT	41	10,350
Urology	42	10,500
EENT	46	11,900
Radiology	48	14,500

What does all this money go for? Among the bigger items the average M.D. paid in 1951 were $2,700 for office salaries, $2,000 for drugs and supplies, $1,150 for office rent, and $900 for automobile upkeep.

Auto Insurance

When I traded in my old car and bought a new one recently, I forgot to notify the automobile insurance company for three weeks. So, presumably, I was driving around in an uninsured car all that time.

Now a friend tells me that my old insurance policy automatically covered the new car. Is this true?

Yes. A new car is covered automatically for up to thirty days, provided all other cars you own are insured

. . . often effective *where oral aminophylline has failed*

. . . often tolerated *where oral aminophylline is not*

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the **new** *oral xanthine medication*

A symposium* on CHOLEDYL was published recently (May, 1954) in the International Record of Medicine and General Practice Clinics. Here are three of the principal advantages of CHOLEDYL over oral aminophylline, as noted in this study—

markedly higher blood levels

". . . the ingestion of choline theophyllinate [choledyl] induced markedly significant increases in the theophylline blood levels when compared to those obtained after aminophylline. The increase was 60 to 75 per cent higher for the first two hours. . . ."[1]

(The therapeutic effect of aminophylline is due solely to its theophylline content.)

minimal side effects

". . . gastrointestinal irritation with choline theophyllinate [choledyl] was a rare occurrence."[2]

no drug fastness

"Of great interest was the absence of the development of tolerance or resistance to the effects of the drug even after choline theophyllinate [choledyl] had been administered to patients for as long as 75 weeks."[3]

CHOLEDYL for *planned* diuresis, *prolonged* coronary vasodilation, *continued* relief of bronchospasm, *relief* and *prevention* of premenstrual tension

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supplied: *100 mg. tablets, bottles of 100 and 500;*
200 mg. tablets, bottles of 100, 500 and 1000.

dosage: *Adults—initiate with 200 mg. q. i. d.—preferably after meals and at bedtime. Adjust to individual requirements. Children over six—100 mg. t. i. d.*

1. Gagliani, J., et al.: Internat. Rec. Med. & Gen. Pract. Clin. *167*:251, 1954. 2. Grossman, A. J., et al.: Internat. Rec. Med. & Gen. Pract. Clin. *167*:263, 1954. 3. Batterman, R. C., et al.: Internat. Rec. Med. & Gen. Pract. Clin. *167*:261, 1954.

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with the same company. The standard automobile policy allows you a month in which to notify the company of any change in car ownership.

Rules for Rx's

I got into a minor hassle this summer for moving my office without notifying the Government that I would henceforth be issuing prescriptions from a new address. Perhaps a quick summary of drug law regulations would be worth publishing. Yes?

Yes. The Harrison Act and the Uniform Narcotic Drug Act require you to follow these two rules:

1. Every prescription you write must give your name, address, and registry number plus the patient's name and *full address*. No prescription may be written in pencil.

2. If you move your office (even across the street), you must notify the District Director of the Internal Revenue Service of the new address within thirty days. Otherwise, the dollar-a-year tax stamp that authorizes you to prescribe narcotics becomes invalid, and legally you forfeit your right to prescribe.

In addition, some state laws require you to keep for two years a record of each prescription that contains opiates or coca leaf drugs. This record must include the quantity and dose of the drug, the diagnosis you made, and the patient's name and address. END

Physiological test compares Kent's "Micronite"

TO COMPARE the efficiency of various filters as they affect physiological responses in the cigarette

Filter with other cigarette filters

smoker, drop in surface skin temperature at the last phalanx was measured.

Using well-established procedures, the subject smoked conventional filter cigarettes and the new KENT with the exclusive Micronite Filter.

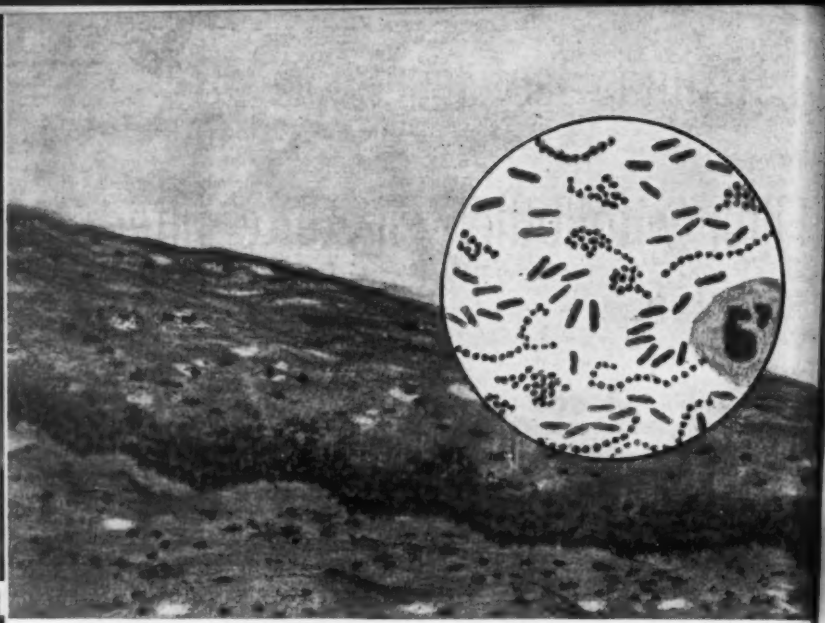
For every other filter cigarette, the drop in temperature averaged over 6 degrees. For KENT's Micronite Filter, there was no appreciable drop.

These findings confirm the results of other scientific measurements that show these facts: 1) KENT's Micronite Filter takes out *far more* nicotine and tars than any other cigarette, *old or new*. 2) Ordinary cotton, cellulose or crepe paper filters remove a small but ineffective amount of nicotine and tars.

Thus KENT, with the first filter that really works, gives the one smoker out of every three who is susceptible to nicotine and tars the protection he needs . . . while offering the satisfaction he expects of fine tobacco.

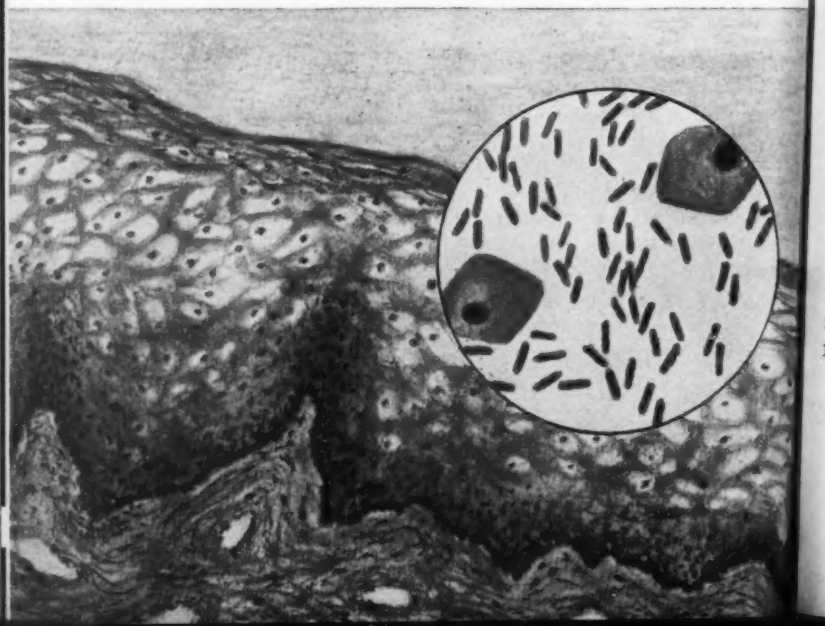
For these reasons, smokers have made the new KENT the most popular new brand of cigarette to be introduced in the last 20 years.

If you have yet to try the new KENT, may we suggest you do so soon?



Above: Senile vaginal epithelium is low in glycogen, low in acid and (inset) low in protective Döderlein bacilli, encouraging growth of pathogens.

Below: Normal vaginal epithelium is high in cogen, definitely acid and (inset) abundan Döderlein bacilli to combat pathogenic organ



Restoring the Normal Acid Barrier to Trichomonal Vaginal Infection

To discourage multiplication of trichomonads and to encourage physiologic protection, a comprehensive therapeutic regimen with Floraquin® is instituted.

THE normal vagina, by reason of its acid reaction, is provided with a natural barrier against pathogenic microorganisms which require an alkaline medium. When the "acid barrier" is removed, a hypo-acid state results and growth of the protective, physiologic and nonpathogenic Döderlein bacilli is inhibited—to be replaced by such pathogenic organisms as the trichomonad, streptococcus, staphylococcus, colon bacillus and Monilia candida.

As infection develops, the epithelial cell layers, which normally number between forty-five and fifty-five, may decrease to as few as fifteen to twelve layers or may disappear entirely. With this loss of glycogen-bearing cell layers, the available carbohydrate released by physiologic desquamation into the vaginal secretion and ultimately converted into lactic acid is proportionately decreased.

Floraquin not only provides an effective trichomonacide (Diodoquin®), destructive to pathogenic organisms, but furnishes lactose, dextrose and boric acid for the reestablishment of the normal vaginal acidity and regrowth of the normal protective flora. G. D. Searle & Co., Research in the Service of Medicine.

Have You Adopted **THE SKIN CARE METHOD** *that*

WRITES OFF BED SORES AND BED CHAFE?

Positive Protection

by lubrication follows routine use of DERMASSAGE—lotion type rub with germicidal hexachlorophene, oxyquinoline and other therapeutic values.

DERMASSAGE *enhances* the benefits of massage and of routine body rubs, reduces bed sores and bed chafe to rare instances

TEMPORARY EASEMENT

with repeated drying out of the skin result from rapidly evaporating rubs, which also make skin susceptible to cracking and soreness.

1000 CC. H_2O
1 CC. ALCOHOL

Due to the marked affinity of alcohol for moisture, the contents of the 1 cc. pipette above, added to the 1000 cc. of water, will be immediately dispersed through it. THUS alcohol tends to remove the natural moisture of the skin when applied to it.

MATERNAL MORTALITY? Steadily declining.

SEVERE SURGICAL SHOCK? Frequency greatly reduced.

BED SORES? Where DERMASSAGE therapeutic lotion rubs are routine, *practically a closed chapter in medical and nursing history.*

Even the vexation of minor sheet burns is reduced to the vanishing point in the overwhelming number of cases where DERMASSAGE care has been adopted.

The reason for success of this method is as inescapable as most other scientific truths, once established: skin chafing and bed sores can be *prevented* in nearly every case by regular application of a softening, emollient rub—especially one which also reduces risk of infection . . . DERMASSAGE not only avoids the skin drying effects of earlier rubs, but gives *positive protection* against chafing and soreness.

Have you adopted the skin care which *defeats bed sores before they develop?*

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Please send me, without obligation, your Professional Sample of DERMASSAGE.

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Address.....

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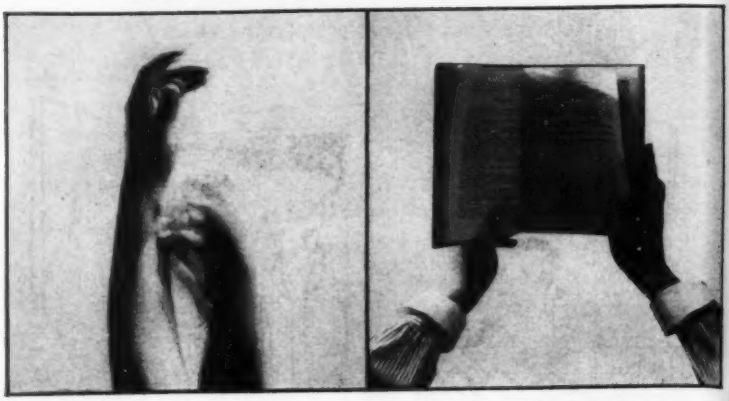
Cutter Laboratories, Berkeley, California

Of two patients with poison ivy...

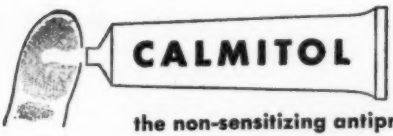


one aggravates the dermatitis venenata by vicious scratching; the result: excoriation and infectious eczematoid dermatitis.

the other is not disturbed by itching. The dermatitis venenata is permitted to clear rapidly and without annoying complications.

Calmitol makes the difference:

Nonsensitizing and free of the dangers of "rebound dermatosis," Calmitol is "preferred"[1] by physicians for its safe and prolonged antipruritic action.



the non-sensitizing antipruritic

1½ oz. tubes and 1 lb. jars

1. Lubowe, I. I.: New York State J. Med. 50:1743, 1950.

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DIETENE is available at all drug stores in plain or chocolate flavors. 1 lb. ($1.59) is full 8-day supply.

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PEDIATRICS BULLETIN

Prepared In The Interests Of The Profession By The Pediatrics Consultant Staff Of H. J. Heinz Company

WHEN THE CHILD NEEDS MEDICINE, THE PARENT OFTEN NEEDS ADVICE

PARENTS of sick children sometimes criticize the doctor for not explaining in sufficient detail how to administer the medicine he so carefully prescribes.

• **It is well for us** to bear in mind that the average parent approaches a routine medical procedure with some apprehension. She is far more likely to meet difficulty when administering medicine than is the trained nurse. Children, quick to sense any unsureness or emotional distress, may refuse to take the medicine—or even cough it up.

• **Obviously,** there are no simple techniques the physician can advise for all situations. Much depends on the training of the child and on his relationship with the parent.

• **Yet if the doctor** will take time to recommend a specific procedure for administering his prescription, he will promote the self-confidence of the parent and, by so doing, facilitate the successful treatment of his young patient.

NOTE: These bulletins are designed to help disseminate modern pediatrics knowledge to the general medical profession and will appear monthly in Medical Economics.

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the right amount of iron

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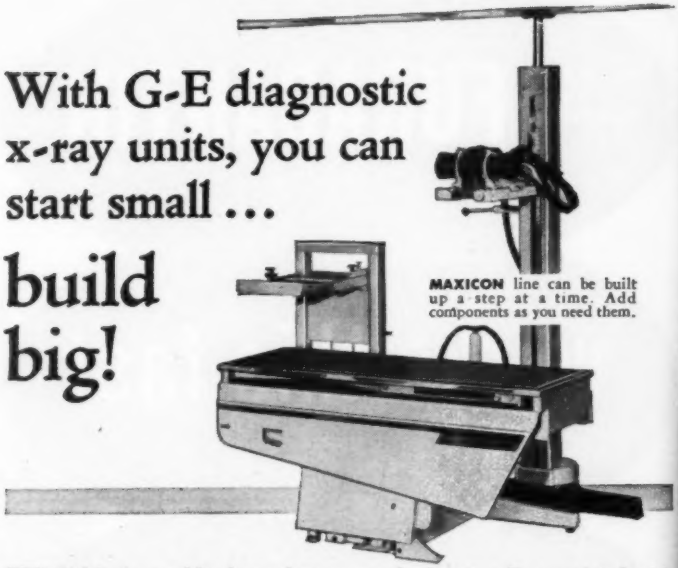
With G-E diagnostic x-ray units, you can start small . . .

build big!



MAXICON line can be built up a step at a time. Add components as you need them.

THE Maxicon table shown here is just one of the broad Maxicon line. In addition, General Electric offers two other types of diagnostic tables:

- MAXISCOPE® that gives you every feature you've sought in conventional x-ray apparatus.
- IMPERIAL that begins where conventional x-ray units leave off with previously unobtainable features.

All three provide modern radiographic and fluoroscopic facilities . . . each is built to the exacting standards naturally associated with General Electric.

And remember — you can get any of these units — *with no initial investment* — under the G-E Maxiservice® *rental* plan. What's more, if you want to upgrade or "trade-in" your rented unit, there's no obsolescence loss.

Get all the facts from your G-E x-ray representative, or write X-Ray Department, General Electric Company, Milwaukee 3, Wisconsin, for Pub. C-8.

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"mental and physical rejuvenation"* with combined estrogen-androgen

*Masters, W. H., and Grody, M. H. Obst. & Gynec. 2:139, 1953.

menopause
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ethinyl estradiol with methyltestosterone

new, improved formulation

two strengths—0.02 mg. and 0.04 mg.

also available as GYNETONE injection.

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SCHERING

Medical Economics
AN INDEPENDENT BUSINESS MAGAZINE FOR PHYSICIANS

Editorial:

Rx for Panel Medicine

● About 3 million Americans now get their medical care through closed-panel health insurance plans. Community cooperatives, labor unions, and some other lay groups seem to like this arrangement.

Private physicians, of course, don't.

They don't because such plans take patients away from them Obviously, this is bad for the doctors. Less obviously, it's bad for the patients, too. They're required to seek care from one of the relatively few M.D.s employed by the closed-panel plans. And such limited choice may mean limited satisfaction—sometimes even limited results.

"But our subscribers join of their own free will," closed-panel enthusiasts retort. "If they don't like our doctors, they're at liberty to withdraw at any time."

This may have been true in the past, but is it necessarily true today? Actually, many subscribers do *not* join of their own free will; they're brought in as a result of union-management negotiations. And they are *not* at liberty to withdraw at any time; if they do so, they lose some of the fringe benefits their employer has agreed to pay for.

These new developments have sharpened doctors' opposition to the closed-panel plans. The question is, what can they do about them?

In our opinion there are two steps we medical men can take:

1. *We can do a better job of publicizing the limited choice of doctor in closed-panel plans.* People instinctively want a personal physician they can have complete confidence in. We need

to show them why, under panel medicine, they may not find what they want.

What words can we use? A medical leader in New York describes one local closed-panel plan this way: "The subscriber . . . must choose one of the groups in his area. In that group there may be about thirty physicians, of whom ten would be general practitioners . . . The subscriber's choice is [thus] limited to one of these ten doctors . . . This is not free choice!"

And in California, advertisements sponsored by the state medical society warn: "Don't let your health insurance plan make you a captive patient!" The ads urge people to buy the type of health insurance under which "you can fire your doctor, or your hospital, and change to any other of your choice, if you are not satisfied."

2. *We can do a better job of competing for the business now going to closed-panel plans.* Much of this business is union business; for labor leaders have shown that they favor comprehensive benefits without surcharges. But closed-panel plans are not the only ones that can provide such benefits.

In Michigan, for example, the doctors behind Blue Shield have offered exceptionally liberal benefits to auto workers. As a result, this free-choice health plan has held the workers as subscribers in the face of stiff competition.

In California, too, the physicians have shown they can give the unions what they want. Negotiating with organized food workers in San Pedro, local physicians pledged that there would be no surcharges for any of them if they would sign up with Blue Shield.

Such competitive concessions—when they can be made without jeopardizing solvency—are probably the most effective answer to panel medicine.

We might also mention the most *ineffective* answer. In our opinion, it's direct retaliation against doctors who choose to work with closed-panel plans. This smacks too much of "conspiring to destroy"—a phrase made familiar by the 1938 anti-trust case against the A.M.A.

Closed-panel plans have been around a long time. They reach some segments of society that our own health plans don't reach. We probably couldn't put them out of business if we wanted to.

What we *can* do is offer a better product—and make sure people know *why* it's better. That's the most constructive way to combat panel medicine.

The Red-Tape Worm

Today more and more doctors' bills are being paid by third parties. A third party can't operate unless its claims files are in apple-pie order. From which it follows that red tape is here to stay.

This probably doesn't bother our

younger colleagues too much. After all, they spent their formative years filling out applications for ration coupons, for Army or Navy commissions, for courses under the G.I. Bill. But some of us oldsters wish we'd taken courses in filling out insurance forms so that they wouldn't be regurgitated by an I.B.M. machine.

Since no one has, as yet, developed such courses, we hereby offer a few suggestions. The catalogue surely ought to include the following:

Elementary Number Transcription. Drill in copying long numbers from identification cards and transcribing them onto vouchers and reports.

Advanced Word Compression. Laboratory work in compressing within limited space a full description of an accident or an operation.

Elements of Prophecy. Practice with crystal ball and Ouija board so as to determine at the start of an illness just when the patient will be able to return to work.

Applied Equanimity. Progressive lessons in preserving aplomb when a voucher is returned because the patient's middle initial was noted incorrectly.

Some doctors, admittedly, will refuse to take these courses. They'll continue to fill out forms in their own individual way. This will be recognized as honorable self-expression. The only trouble is, some of the self-expressers won't get paid.

You can learn to live with the red-tape worm. Sometimes this is better than trying to kill it off.

—H. SHERIDAN BAKETEL, M.D.

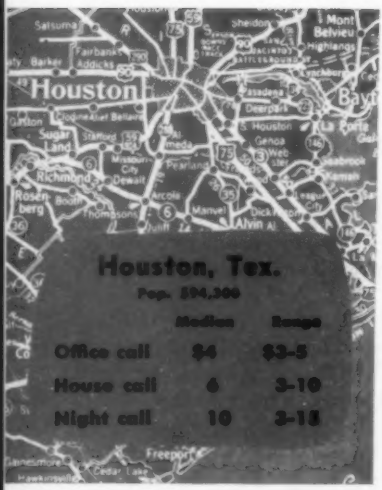
How Much Do Doctors Charge?

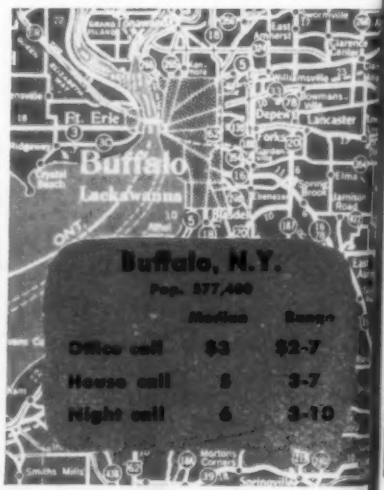
A* MEDICAL ECONOMICS *report on the current fee practices of G.P.s in twelve selected cities

By Kenneth P. Andrews

● What are physicians charging these days for ordinary medical services? To get a rough idea, this magazine has polled a cross-section of independent general practitioners in a dozen selected cities* across the country.

*Houston, Tex.; Buffalo, N.Y.; Minneapolis, Minn.; Seattle, Wash.; Memphis, Tenn.; Savannah, Ga.; Fall River, Mass.; Lincoln, Neb.; Glendale, Calif.; Independence, Mo.; Reno, Nev.; and Charlottesville, Va.





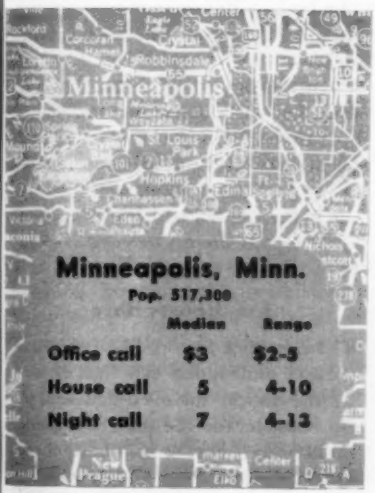
These doctors were asked, in effect, two main questions:

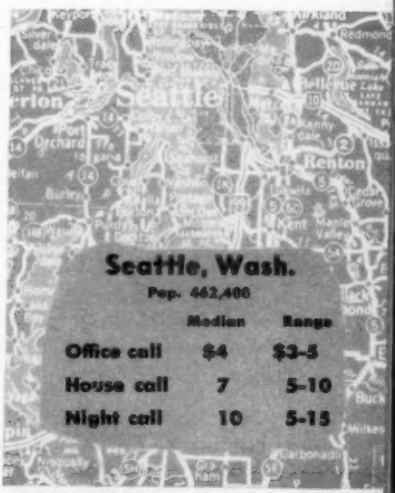
1. What are your present fees for (a) office visit; (b) house call; (c) night call?

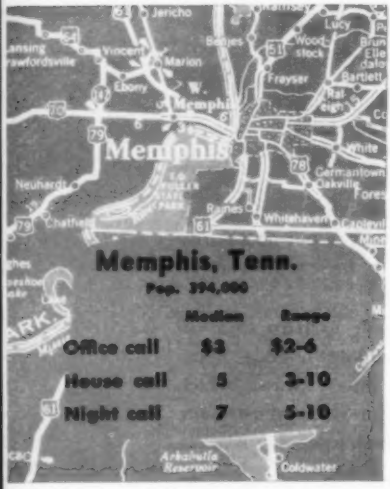
2. What were your fees two years ago for the same types of service?

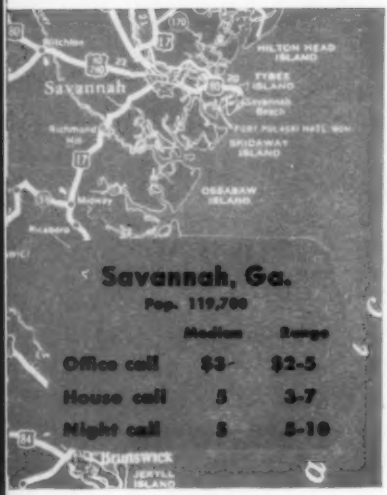
Since the surveyed men practice in cities ranging from 25,000 to 600,000 in population, they're not necessarily typical of G.P.s as a whole. Even so, their replies are an interesting straw in the wind.

The twelve selected cities provide a sharp study in contrasts. One of them is that well-known Texas boom town: Houston. Another is Fall River, Mass., which stands a good chance of becoming a textile ghost town. Then there's Seattle, gateway to the burgeoning Alaskan









frontier, and Savannah, magnolia-rooted in the Southern past. There's Glendale with its Spanish architecture and Charlottesville with its old-colonial. And so on.

But despite the contrasts among the cities themselves, there's little variation in the fee schedules of the G.P.s who inhabit them. In eight of the twelve cities, for example, the prevailing office-call fee is $3; in nine of the twelve, the $5 house-call fee prevails. Greater variation, it's true, shows up in night calls: The median fees for this service range from $5 in Savannah to $10 in Houston, Seattle, and Glendale.

As you'd expect, doctors in the two West Coast cities tend to charge somewhat higher fees than those in other cities. In general, too, fees in the larger cities seem to run slightly higher than those in the smaller places.

On the other hand, there's no indication that doctors just out of interneship charge very much less than those with considerable experience. In some cities, in fact, the fees of G.P.s who've had less than two years of private practice would seem to exceed the average.

Fee Boosts Rare

In spite of factors like rising expenses and added experience, few of the doctors surveyed had seen fit to boost fees in the past two years. Where fees *had* been raised, there was generally a specific reason for the increase: E.g., it helped c

down the number of unnecessary house calls.

In this connection, 24 per cent of the doctors surveyed had boosted night-call fees since spring, 1952, and 21 per cent had hiked charges for ordinary house calls. By contrast, only 15 per cent had raised office-call fees during the same period.

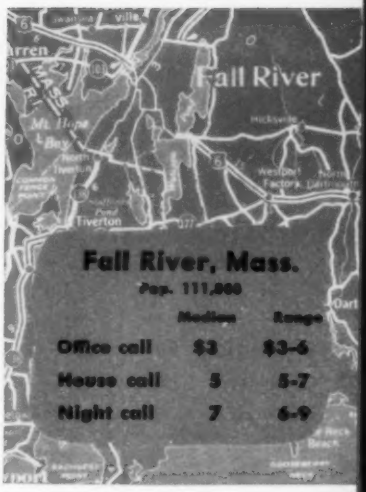
The great majority of G.P.s seemed reluctant to raise *any* of their fees. Only in Glendale was there a noticeable trend upward—and even here, less than half the surveyed men were charging more than they had two years ago.

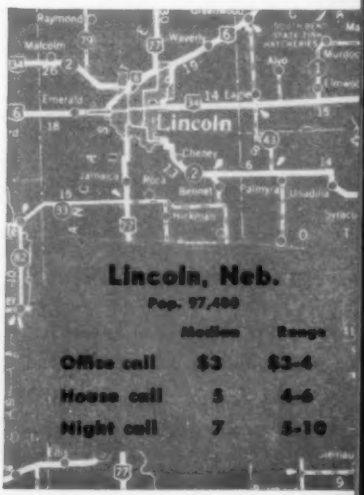
Times Have Changed

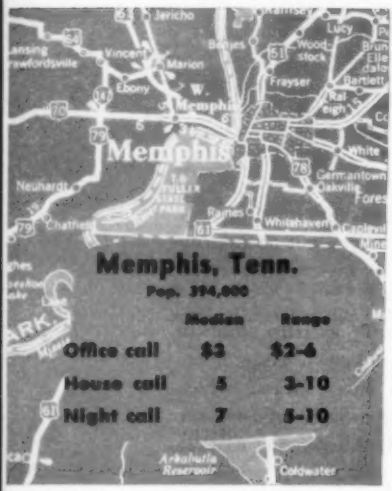
This general hold-the-line policy, of course, ties in with the fact that cost-of-living indexes have tended to level off since 1952. When MEDICAL ECONOMICS surveyed G.P.s in the same twelve cities a couple of years ago, the situation was quite different: From 1946 through 1951 (obviously a period of sharply rising prices), fee boosts of from one-third to one-half were the rule rather than the exception.

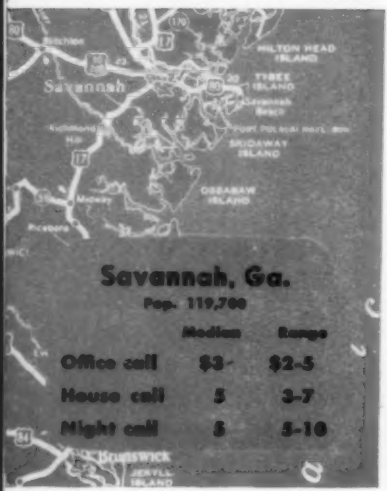
Even among the minority of doctors who say they've raised fees since 1952, however, the usual increase is only $1. This seems to be true of almost every G.P. who has raised his office-call fee, and of seven out of ten doctors who have upped house-call charges.

For night calls, the picture is a bit different: The most common increase here is $2. [MORE→









frontier, and Savannah, magnolia-rooted in the Southern past. There's Glendale with its Spanish architecture and Charlottesville with its old-colonial. And so on.

But despite the contrasts among the cities themselves, there's little variation in the fee schedules of the G.P.s who inhabit them. In eight of the twelve cities, for example, the prevailing office-call fee is $3; in nine of the twelve, the $5 house-call fee prevails. Greater variation, it's true, shows up in night calls: The median fees for this service range from $5 in Savannah to $10 in Houston, Seattle, and Glendale.

As you'd expect, doctors in the two West Coast cities tend to charge somewhat higher fees than those in other cities. In general, too, fees in the larger cities seem to run slightly higher than those in the smaller places.

On the other hand, there's no indication that doctors just out of interneship charge very much less than those with considerable experience. In some cities, in fact, the fees of G.P.s who've had less than two years of private practice would seem to exceed the average.

Fee Boosts Rare

In spite of factors like rising expenses and added experience, few of the doctors surveyed had seen fit to boost fees in the past two years. Where fees *had* been raised, there was generally a specific reason for the increase: E.g., it helped cut

down the number of unnecessary house calls.

In this connection, 24 per cent of the doctors surveyed had boosted night-call fees since spring, 1952, and 21 per cent had hiked charges for ordinary house calls. By contrast, only 15 per cent had raised office-call fees during the same period.

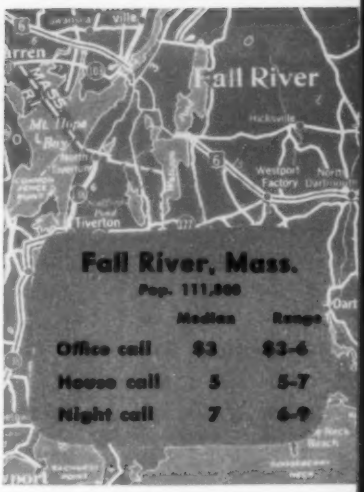
The great majority of G.P.s seemed reluctant to raise *any* of their fees. Only in Glendale was there a noticeable trend upward—and even here, less than half the surveyed men were charging more than they had two years ago.

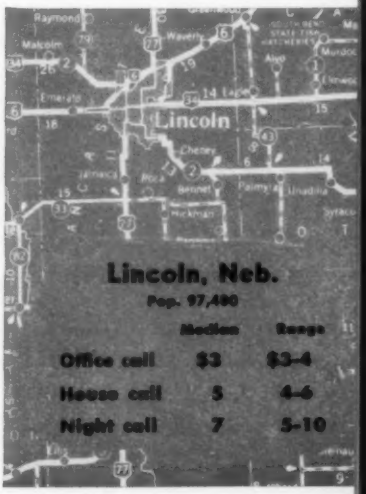
Times Have Changed

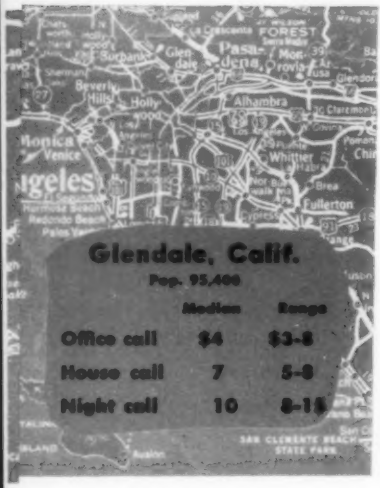
This general hold-the-line policy, of course, ties in with the fact that cost-of-living indexes have tended to level off since 1952. When MEDICAL ECONOMICS surveyed G.P.s in the same twelve cities a couple of years ago, the situation was quite different: From 1946 through 1951 (obviously a period of sharply rising prices), fee boosts of from one-third to one-half were the rule rather than the exception.

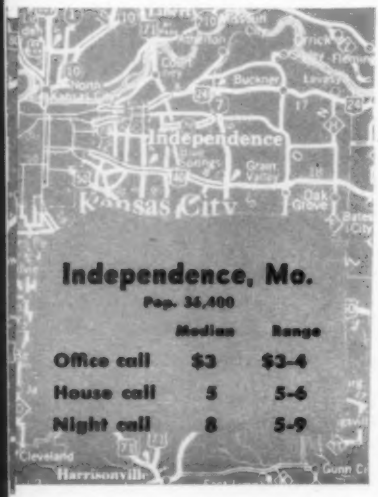
Even among the minority of doctors who say they've raised fees since 1952, however, the usual increase is only $1. This seems to be true of almost every G.P. who has raised his office-call fee, and of seven out of ten doctors who have upped house-call charges.

For night calls, the picture is a bit different: The most common increase here is $2. [MORE→









Why have some doctors raised their office fees? Only a handful justify any such action by pointing out that they're dispensing a higher grade of medical service nowadays. The "cost-of-living" justification is by far the most common reason given.

Sample remarks:

¶ "Everything costs more today."

¶ "I moved from group practice into a rather elaborate solo-practice set-up; and so overhead went up."

¶ "My group raised fees the first of the year because of marked increase in overhead."

¶ "I've had to hire another girl to handle the sundry insurance forms that patients deluge me with these days."

Why They Stand Pat

More significant, perhaps, are the comments of physicians who have *not* raised fees recently.

"Competition too keen," says a Memphis G.P. "I don't feel that the traffic would bear the increase." To which a Buffalo physician adds: "I haven't been in practice long enough to pioneer for changes in my neighborhood."

In several cities, medical-society-sponsored fee schedules seem to have had a leveling effect on the schedules of individual G.P.s. Seattle's unusual health-insurance plan (discussed in MEDICAL ECONOMICS, May, 1954) appears to have had a similar influence.

Some physicians, moreover, speak

of the "hard times" that have struck their areas during the past several months. Observes a Memphis doctor:

"My fees will not be increased in 1954. This is due to the fact that my practice chiefly involves persons who work for industrial plants. In 1953, these men could get at least five days' work a week, and most weeks they got overtime. Now there's very little overtime, and some of the men just work two or three days weekly."

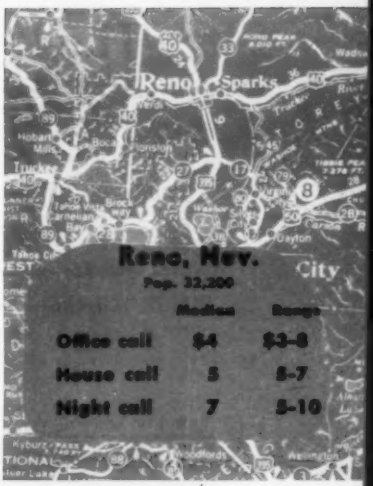
'Collections Are Bad'

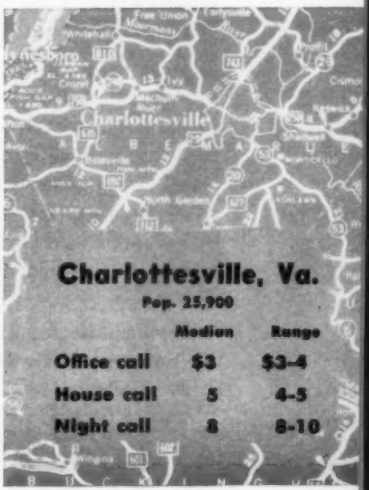
In circumstances like these, some of the G.P.s point out, fee rises would be bad medicine—economically as well as psychologically.

"Collections are already poor enough," bluntly states one doctor. "I'd rather charge $3 for an office call and stand a chance of getting paid than charge $5 and never hear from the patient again."

An occasional doctor has tried a fee rise, only to go back to his old schedule. One such physician adopted a higher schedule for new patients last year, but continued to bill old patients at the lower rate. Word got around that he had two sets of fees—and the resulting furor persuaded him to return to his old schedule for all patients.

Finally, there's the matter of income tax. "Why should I raise fees and antagonize patients?" asks a Houston G.P. "Let *them* pay the money to Uncle Sam." END





'The Best Three-Man Office I've Seen'

That's what a management consultant who has inspected over 600 doctors' buildings says about this one. Its cross-shaped floor plan assures each M.D. maximum privacy, minimum walking

By Lois Hoffman

● For several years, Duward L. Finch and Donald B. Morrison had been carrying on a growing general practice in rented quarters in downtown Battle Creek, Mich. They were crowded for space—but there was no way to add the extra rooms they needed. As a result, they felt they were running their practice inefficiently and working harder than they needed to.

So, when they took on a third partner, Alfred G. McCuaig, they decided to put up their own building.

Dr. Finch sketched a rough floor plan, in the cross shape used in many hospitals. Each doctor was to have his own private wing with four treatment rooms and a consultation room. The fourth wing and the center of the building would hold the reception room, business office, lavatories, and laboratory.

Architect John Burgess worked out the details. In the basement he put a caretaker's apartment, an office suite (now rented to a dentist), and a nurse's lounge, as well as some extra rooms that could be used for diagnostic tests or for storage.

There's room for thirty-five cars in the parking space in

front of the building. The physicians use the three-car garage in the rear.

Since early 1953, when the three doctors opened their new office in Lakeview, a suburb of Battle Creek, they've been seeing about 150 patients a day. Six nurses and two secretaries take care of the routine chores.

"This building," says Dr. Morrison, "lets us do more work in less time. We all get home earlier than we used to, and we take more time off. I wouldn't change a thing about the office or the way we run it." His partners agree.

What do patients think of it? One of them expressed his opinion recently in the words of Jimmy Durante: "It's colossal!"

FRONT OF BUILDING was designed originally with corner windows on either side of the large center window in the reception room (see floor plan, next page). But the doctors ruled them out, in order to shield waiting patients from view of passers-by outside. (Actually, translucent glass, draperies, or other means could have been used to gain the same end.)

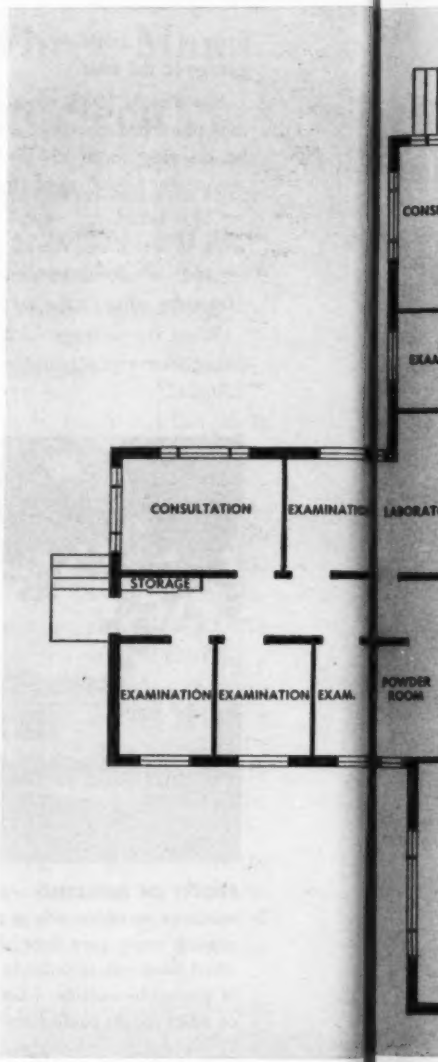
[MORE➤

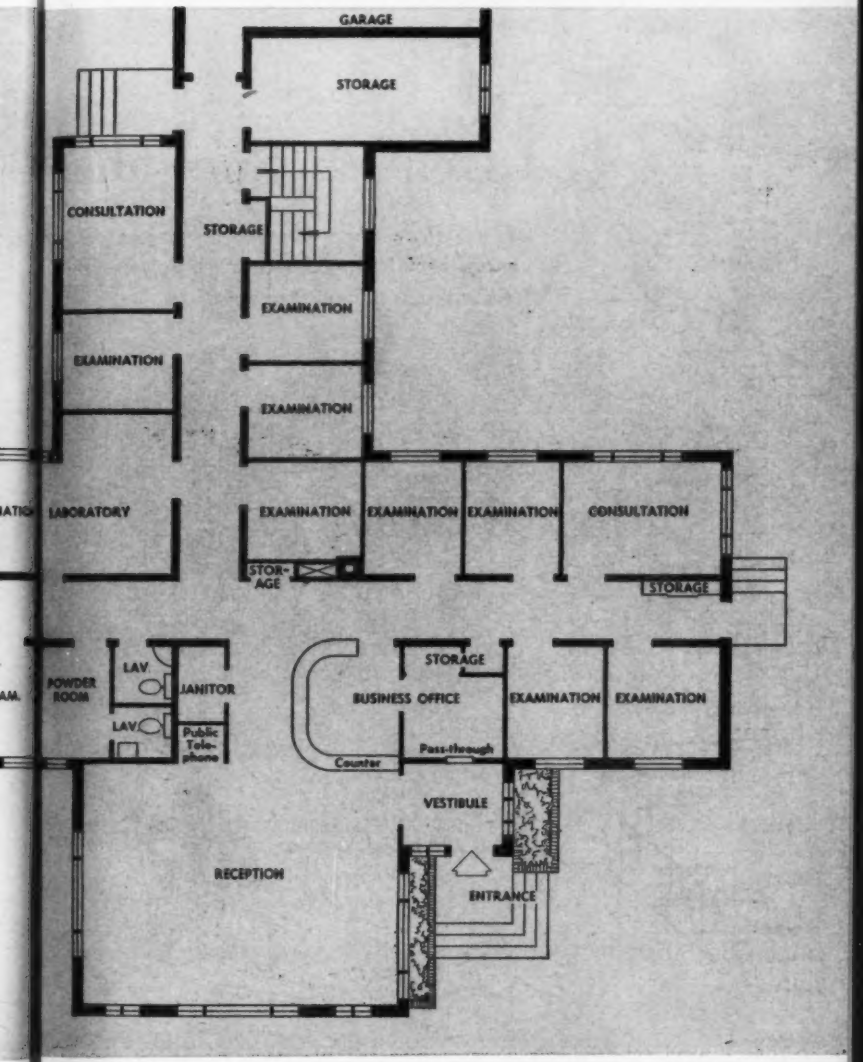
OUTSIDE LIGHT is plentiful in almost all the rooms. This and other advantages of the cross-shaped building help offset its somewhat higher construction and maintenance costs.

STEP-SAVING results from arranging each doctor's examining and consultation rooms in a cluster instead of stringing them out. Needless walking is also avoided by placing the laboratory near the business office and by having the lavatories just around the corner from the reception room.

TRAFFIC FLOW is smooth because of the carefully thought-out floor plan. Patients and other callers come directly to the open counter beside the entry, without having to walk through the reception room first. When a patient leaves the examining room, he has no trouble finding his way back to the entrance of the building.

PRIVACY is gained by the simple device of a jog in the corridor, which screens the rear-wing treatment area from the waiting room. Each doctor works uninterruptedly in his own suite; when necessary, he can use the intercom to call one of his colleagues or the business office. And since each examining room has but one door, no one is likely to walk in by mistake. END

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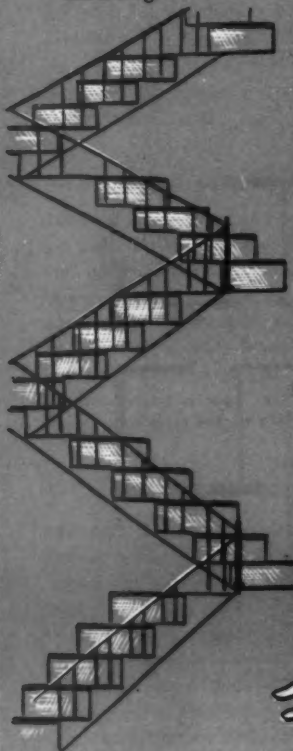
STOR-AGE
STORAGE
POWDER ROOM
LAV.
JANITOR
LAV.
Public Tele-phone
STORAGE
BUSINESS OFFICE
EXAMINATION
EXAMINATION
Counter
Pass-through
VESTIBULE
RECEPTION
ENTRANCE

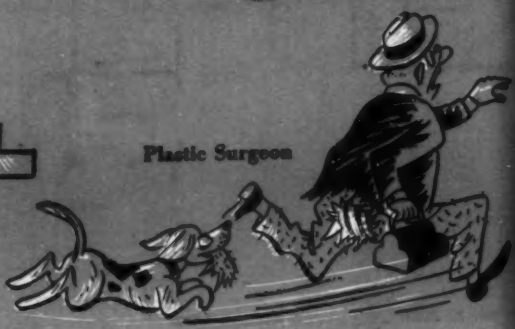
The General Specialist

The G. P. making a house call is a man of many specialties. He has to be. Or he'd never get through the day's rounds.

Cardiologist



Ophthalmologist



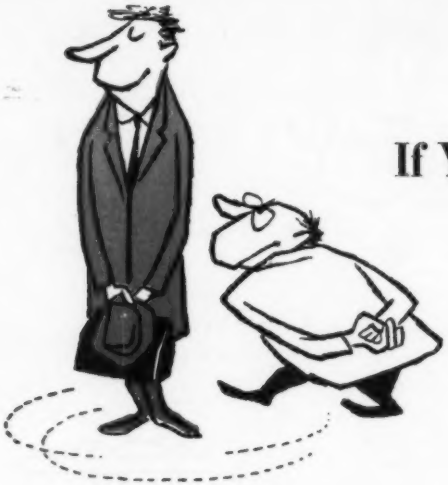
Plastic Surgeon

Gastroenterologist

Otologist

Anesthesiologist

Neurologist



If You Need a

● A doctor from Detroit came into our office the other day. "I've been reading a lot about combined practice," he said, "and I'm convinced that it would be a good thing for me. The trouble is, I don't know any doctor I'd like to combine with. Can you suggest how I might go about finding one?"

By way of reply, we showed him a copy of a letter that another doctor had written. It reflected this M.D.'s efforts to solve the same problem. He had appealed to the chiefs of service at twenty-one Midwestern teaching hospitals as follows:

"DEAR DOCTOR: Urgent need for a board-qualified associate in nose and throat prompts me to write and ask your assistance. My practice is already large enough for two men; in fact, I am actually having to postpone care for patients in real need of attention. I have a newly re-

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**For some twenty years, the authors have operated Professional Management of Battle Creek, a firm that today has doctor-clients in a number of states.*

ed an Associate

By Henry C. Black
and Allison E. Skaggs

Here's useful advice on locating a good man, signing him up, paying him adequately, and giving him some incentives to stay with you

modeled office, designed with ample space for two doctors, and staffed with pleasant, well-trained girls. I have my boards and am 64 years old.

"In addition to paying a good salary for the first year, I expect to sign an agreement to form a partnership at the end of that time, with a progressively increasing percentage for the new man, resulting in equal earnings after just a few years.

"There are about 80,000 people in this area. They are served by five physicians who specialize in ear, nose, and throat (four of them are over 60 years of age). Living conditions are excellent; the medical profession is friendly and free from feuds.

"I'll be most appreciative if you'll publicize this request and have interested men phone me collect . . ."

Our visitor finished reading the letter and reflected a moment. Then he said:

"If I were a young nose and throat man, I'd say that letter spelled OPPORTUNITY in capitals." [MORE→

"Exactly," we replied. "And that's the secret of attracting a good associate. You want a young man who'll develop into a successful partner. The trick is to figure out what *he* wants—and then offer it in such a way that he's bound to take notice."

Young Man's Fancy

What *do* young doctors want nowadays? The evidence is that they want to work closely with top-caliber physicians. They want good hospitals near-by. They want a pleasant place to live—and enough time off to enjoy it. They want a respectable salary to start with, plus the promise of a percentage share if all goes well.

Attracting an associate, then, is simply a matter of appealing to these basic motives. Here's how you can set about it:

What Have You Got?

1. *Begin by analyzing the specific advantages you can offer.* You'll eventually have to describe these advantages in conversations, in letters, perhaps in classified ads. It pays to figure out ahead of time which ones have greatest appeal.

For example, take professional advantages. Are you board-certified? Can you point to some comparable recognition? Is your office unusually well equipped or well staffed? Such things are likely to impress a young man—especially one fresh from medical-center training.

Next, consider your community. Is it prosperous? Are the schools good? Why, in short, should anyone want to move there?

Matter of Money

Then consider financial offers. Starting salaries of from $600 to $800 a month for young associates are quite common these days. If a good man would be worth more to you, you're in a strong competitive position. (The ENT man whose letter is quoted above decided he could offer at least $1,000 a month to start.)

More important than starting salary is the future financial outlook. Can you offer a percentage of profit—say, 30 per cent of net income—after a year or two? Can you offer full partnership within a relatively short time? Such incentives not only attract good men but make them want to stay.

2. *Start searching for an associate within the professional circles you know best.* Your hospital, your medical school, your medical society are likely to be the most reliable sources. They're reliable because you can see your prospects in action, and because you can check the opinion of friends. These factors helped produce two of the most successful combinations we've known:

¶ In Chicago, two surgeons decided to combine. One was 61, the other 44; they had become close friends through work in the same hospital.

¶ In Detroit, two internists joined

forces. One was 52 and a part-time professor; the other was 30, a former student of his.

Should your inquiries be kept within the profession? Not necessarily. Two Michigan G.P.s told a well-regarded equipment salesman they were looking for a new associate. He passed the word to some doctors on his route, and a young man fifty miles away responded. He turned out to be just right for the job; today he's a full partner.

How to Advertise

3. *If local sources fail, take to the open market.* This means advertising in state and national medical journals (and perhaps registering your needs with medical employment agencies). A good preparation for this is to analyze the ads already appearing in the Journal A.M.A. It doesn't take long, for example, to discover that the following type of ad is too vague to be effective:

> INTERESTED IN FINDING SOMEONE who would become associated with me in an excellent pediatric practice; wish to retire soon. Box 123.

For contrast, read the following ad and see how much more punch it packs:

> OBSTETRICIAN WANTED to associate with diplomate; large Eastern city; beginning $10,000; early partnership. Box 456.

Naturally, the phrases you use should stress your strongest selling points. For example: "rapidly expanding practice in beautiful university town" . . . "three excellent hospitals within 15 miles" . . . "time allowed for post-graduate courses" . . . "partnership assured in writing."

Before You Interview

4. *Screen out the poorest prospects and interview the best.* Remember that your ads will bring responses from some misfits—men who aren't happy in their present work and probably wouldn't be happy in yours. If the candidates' letters don't reveal enough about them, write them direct to elicit further information. Or send them a form questionnaire. Whichever way you do it, be sure to investigate such points as:

¶ Marital, military, and health status;

¶ Practice experience to date;

¶ Approximate present earnings;

¶ Licenses and certificates held;

¶ Names and addresses of references.

After you've sifted through the replies, it's time to invite the prospects in for a personal interview. If they have to travel some distance, it's appropriate to pay their expenses. Have each bring his wife, so that you and your wife can take them to dinner. (How the four of you get along may be more revealing than any letters of reference.)

Before you decide in favor of any candidate, though, better check his references. His hospital and his medical school may be the most im-

portant sources to write. The opinions of any mutual friends in the profession can also be helpful. But don't attach too much importance to letters from lay people you don't know.

The Written Contract

5. *When you find a good prospect, go ahead and sign him up.* We mean that literally; a written employment contract is the best way to prevent misunderstandings. It should state the terms—salary, automobile allowances, time off, and such. And it should point toward the future, in some such words as these:

"It is the intention of the parties hereto that at the end of the term of this contract they will, if possible, mutually agree to form a partnership; and that the partnership contract will specify such a percentage of net income to be paid to the second party as will amount to not less than his earning under the present contract of employment; and that such percentage shall be progressively increased over a period of five years until reaching equality . . ."

How Practices Increase

Is a good associate really worth all this trouble? Well, here are three significant cases in point. Note particularly the effect on the existing practice:

¶ A general physician, aged 42, practiced in a small Michigan town that had just built a community hospital. It began drawing patients from outlying areas, and pretty soon the doctor needed help. His ad in the state medical journal was answered by another G.P. (aged 34) who practiced in an almost identical town *without* a hospital. The second doctor moved in with the first, at $7,500 annually to start. The practice had been grossing $30,000; a year later it was grossing $45,000.

¶ An internist, 47, discovered during his Army service that he liked combined practice. Soon after he got back to Wisconsin, he advertised in the Journal A.M.A. for an associate. One of the men answering his ad was a 35-year-old internist he'd met in service. Upon his release from the Army, the second man was hired at a starting salary of $12,000 a year. The practice had been grossing $20,000; a year later it was grossing $40,000.

¶ A 54-year-old surgeon from Indiana visited a hospital in another state where his sister was a patient. She spoke glowingly of the treatment she'd received from a surgical resident. The two men met and got to know each other. Several months later, the older man offered the younger one an associateship at $10,000 a year. The practice had been grossing $40,000; a year later it was grossing $65,000.

The most practical reason, then, for seeking out a really good associate may well be this: It pays!

END

New Light on Itemizing

Do you still submit those all-embracing bills 'For Professional Services'? Here's why many doctors now believe it's better to be more explicit—with some tips about how they do it

By Malcolm C. Davis

● "Look, Doctor," the patient said, angrily: "I don't like to make an issue over a few bucks; but when I get a bill for $29 just for fixing a sore finger, I think I've got a right to know why!"

Just for "fixing a sore finger"? The physician's records showed that there'd been an infection requiring daily penicillin shots and that the patient had made a total of six visits to the office.

Six visits at $4 each: $24. Five penicillin shots at $1 each: $5. The fee could hardly be considered excessive. Why, then, had the patient complained?

The obvious answer: (1) The monthly bill had shown only the total amount due. (2) The patient, after a few weeks, had forgotten the full extent of his treatment.

In a way, it was lucky for the physician that this patient did complain. Another patient might have reacted by simply "forgetting" his bill—or by telling his friends about Dr. X's "exorbitant" fees.

This incident (which happened some time ago) convinced the doctor of the wisdom of itemizing *all* his bills from then on. "Sure, it means a bit of extra work for my aide," he now says. "But who knows how much real trouble it saves her and me in the long run?" [MORE→

NEW LIGHT ON ITEMIZING

Recently, MEDICAL ECONOMICS asked a number of representative physicians for their current thoughts on itemizing. And most of them said they were completely sold on the idea. Some of their reasons:

Good Psychology

1. *A patient who's given a detailed list of services rendered is less likely to imagine that he's been overcharged.*

Says a Californian: "I've found that itemization has a good psychological effect. It makes the patient aware of exactly how much has been done for him."

An Iowan adds: "It's surprising how often patients honestly forget some important part of their treatment. And the less they remember, of course, the higher the charge looks to them. So I itemize my bills to refresh their memories."

Shows Not All for You

2. *An itemized bill distinguishes between the doctor's fee and other charges for tests, medications, etc.*

The patient who gets a lump-sum bill may well assume offhand that every cent he pays goes right into the doctor's pocket. Itemizing averts such misunderstanding. "We've found that when our bill tells the patient what items or procedures she's being charged extra for, she usually pays up without question—even though she may not know what some of the things listed mean," says a Philadelphia gynecologist.

3. *Itemizing speeds up collections.*

A Delaware G.P. remarks that "Each specific entry acts as a separate prick to the patient's conscience. What's more, it gives the patient little excuse for putting the bill aside to discuss with the doctor later. Itemized bills answer the questions before they're asked."

'Mine's More Than His'

4. *An itemized bill gives the patient less reason to make unfair comparisons between his doctor's fees and those of another.*

This point is hammered home by a Chicago internist: "Lump-sum bills for similar series of treatments may seem to the layman to *invite* comparison," he says. "But we all know how seldom two series of treatments exactly parallel each other. That's why I avoid even such a seemingly specific term as 'Blood tests.' One M.D. may use the term to cover tests costing three times as much as those given by another."

Creates Goodwill

5. *An itemized bill reminds the patient tactfully whenever he's received a service free or at a reduced charge.*

A Cincinnati gynecologist makes no charge for the check-up office visit following electrocoagulation of the uterine cervix. But his secretary lists the visit ("No charge") on the bill for the cauterization. She also indicates hormone or vitamin injec-

tions given during an office call, although there's no extra charge for these either.

"When a physician reduces his fee," says Joseph F. McElligott, a medical management consultant, "he should get credit for it. Take a case I came across recently:

"All three youngsters in a family were sick in bed. The doctor made four house calls and treated all the children each time. At his regular fee of $5 a call, he could conceivably have sent a bill for $60. But he decided to charge only half as much. When the family got his itemized

PLEASE LEAVE THIS SLIP WITH RECEPTIONIST

GEORGE J. LUTTRELL, M.D.
EVANSTON, ILL.

Date July 15, 1954

Patient's Name Alfred Jansen

OFFICE CALL	✓	4.00
HOUSE CALL		
NIGHT CALL		
SURGERY		
INJECTION Penicillin	✓	1.00
DRUGS		
LABORATORY Blood count	✓	5.00
TOTAL		10.00

Next Appointment (2 wks.)
3 p.m., July 30, 1954

CHARGE SLIP looks like this at end of typical visit. It makes for easy itemizing, as shown on following pages.

bill, they appreciated the fact that he'd given them a break."

6. *Since patients get itemized bills from most of their other creditors, they're coming to expect them from the doctor, too.*

"If a plumber charged me $150 'for services rendered,'" said a Georgia M.D., "he'd get his bill back fast and be asked to itemize it. I think my patients have the same right to know what *they're* paying for."

The above six reasons, then, represent the *why* of itemizing. But what about the *how?*

Is it possible to itemize all initial statements in the average medical office without taking too much time? Yes, it is—though the most feasible method has not yet been widely used except in some branches of business.

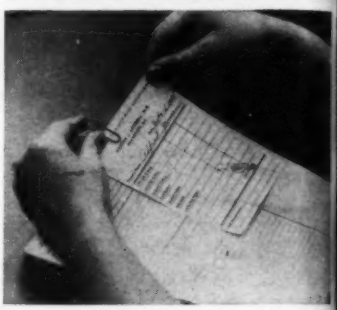
This method is the charge-slip method. And physicians who are not now using it may well give it serious consideration.

The charge slip is a simple printed form that measures, say, 4" x 6". It has spaces in which to write the patient's name, the services rendered him, and the charges for those services. (Such slips have been described in MEDICAL ECONOMICS before, though not mainly in relation to itemizing.)

How do you use the charge slip as an aid to itemizing? The accompanying photo sequence tells the story in step-by-step detail.

[MORE TEXT ON 123]

Ten Simple Ste



1. SECRETARY STARTS the charge slip on its rounds. She keeps a pad of slips at her desk. Before a patient sees the doctor, she writes his name and the date on a charge slip and attaches it to his case history form.

4. DOCTOR HANDS his office patient the charge slip when the consultation or treatment is finished. He accompanies it with some such request as: "Would you mind leaving this with the receptionist on your way out?"

oduce an Itemized Statement

DOCTOR RECEIVES the charge slip and the case history before he sees the patient. This procedure is followed even on hospital and house calls; the secretary simply makes up the necessary forms in advance.

3. DOCTOR NOTES the services rendered by means of check-marks at the end of the visit. He also itemizes some services by name. He may even write in the fee himself; but in routine cases, the secretary does this later.

5. PATIENT SEES an itemized report of the services he's received, including injections given, drugs furnished, and laboratory tests made. En route to the secretary's desk, he has an opportunity to study the details.

6. SECRETARY COMPLETES the charge slip by writing in the appropriate fees (if the doctor hasn't) and the date and time of the patient's next appointment (following any instructions the doctor noted on the slip). [MORE➤

Producing an Itemized Statement (*Cont.*)

7. SECRETARY SHOWS the completed charge slip to the patient, pointing out (among other things) the total amount due. This lets the patient know exactly what he's being charged—and often encourages him to pay cash.

8. SECRETARY TRANSFERS the amounts shown on the charge slip to the patient's financial record. If the patient hasn't already paid, the charge slip is filed directly behind his financial card until the end of the month.

9. SECRETARY GETS the charge slip out of the financial file at the end of the month, when it's time to type up statements. Instead of itemizing the statement itself, she need only attach the original charge slip to it.

10. PATIENT RECEIVES his original charge slip stapled to the statement sent him. This reminds him of the specific services rendered—and thus answers questions he might otherwise have about the bill.

There are, of course, other ways to itemize bills without spending too much time on the job. For example:

Other Methods

You can have printed at the bottom of your billhead a list of the commoner services and items you furnish, each followed by a simple designation. *Office Call* may then be typed as "OC"; *Basal Metabolism* as "BM"; etc. This method of itemizing requires some extra typing, but not much. It's useful in an office where the doctor doesn't do many elaborate procedures.

Another quick means of itemizing is with an electrical bookkeeping machine. Such a machine can be yours for as little as $600—which of course can be deducted as depreciation, over a period of years, on your subsequent income tax returns. Each of the machine's keys will record on the billhead a typical service or item. The time saving here stems from the fact, of course, that it's a lot quicker to punch one key for, say, *Electrocardiogram* than to type the word out in full or even type an abbreviation of it.

This method of itemizing is best suited to large practices. It has proved practical, however, in some offices where as few as 400 statements per month are prepared and sent out.

But of the several quick methods of itemizing, the charge slip is probably the cheapest, easiest, least time-consuming, and most adaptable to the average medical office.

For years, most doctors have either not itemized their bills—on the ground that itemizing would take too long—or they have itemized on a sort of compromise or halfway basis.

Some, for instance, have followed the policy of sending itemized bills only to a few patients whose charges were especially complicated. Some have shown on their bills simply the breakdown between charges for house, office, and hospital calls.

Others have made only a gesture toward itemizing by including this notice at the bottom of each statement: "The individual items that make up this account may be inspected at my office."

Good Cement

But there are at least a minority of doctors who've come to appreciate the value of itemized bills in cementing relations with patients. And they're quick to point out that halfway methods just aren't enough, because they leave too many unanswered questions in patients' minds. These unanswered questions, they emphasize, are among the things that most seriously mar an otherwise smooth-running practice.

As more and more doctors realize the validity of this view, and as they learn how easy itemizing with charge slips is, this practice may well become the rule, rather than the exception. END

Labor Demands Full Coverage

► Union health and welfare funds have grown into a billion-dollar business, covering two-thirds of the nation's 16 million organized workers. So, in the years ahead, labor will unquestionably play an important part in determining how America's medical-care costs will be financed.

A good example of labor's power—and of its ravenous appetite for "fringe" benefits—is the series of contracts negotiated last year between the major rubber companies and the United Rubber, Cork, Linoleum, and Plastic Workers of America (C.I.O.). Under these agreements, almost 500,000 persons—mainly rubber workers and their families—now have hospitalization and medical-surgical insurance of the Blue Cross-Blue Shield type. The entire cost of this insurance is borne by their employers.

There's evidence that other big unions, following the rubber workers' lead, will soon demand industry-wide health coverage. For this reason, the editors believe that physicians everywhere will want to know what the program has meant to doctors in the rubber capital of Akron.

—at Doctors' Expense

When a big union wins a company-financed health plan for its members, doctors may be the losers. Take what's happening in one area . . .

By Wallace Croatman

● On April 4, 1953, a two-day strike of 35,000 United States Rubber Company employes ended with the signing of a new contract. It included provisions for a broad program of health insurance—with the employer paying the premiums.

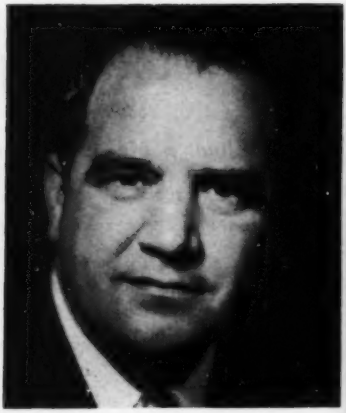
Doctors in Akron, Ohio, hadn't been in on the negotiations, but they had a vital interest in the outcome. One out of five persons in the city works in the rubber industry; and the U.S. Rubber settlement was pretty sure to set a pattern for the rest of the industry.

Still, the physicians saw no cause for alarm—at first. In general, the announced plan seemed to follow the classic Blue Cross-Blue Shield formula. Patients were to have free choice of physician, for instance; and insurance payments could be assigned to the doctor direct. Moreover, the fee schedule was expected to be rather generous.

They got their first hint of trouble in May, when Joseph W. Childs, the United Rubber Workers' vice president, and other union officials met with the Council of the Summit County (Akron) Medical Society.

The union men had prepared a fee schedule, supposedly patterned after Blue Shield schedules in a number of states. "Will you agree to have your members accept the insurance allowances as payment in full for

George R. Bass



Joseph W. Childs

UNION LEADERS: "The doctors were damned indifferent."

covered procedures?" they asked. The M.D.s declined.

So the labor leaders shifted their attack. Would the medical society suggest another pay-in-full plan? Again, the doctors refused. As the then-president of the medical society, Dr. Millard Beyer, explains:

"We decided we wouldn't be bound by any such plan. We were not negotiating with anyone. We were just offering services to the public. It was none of our business *what* the rubber companies negotiated."

Two Dangers Cited

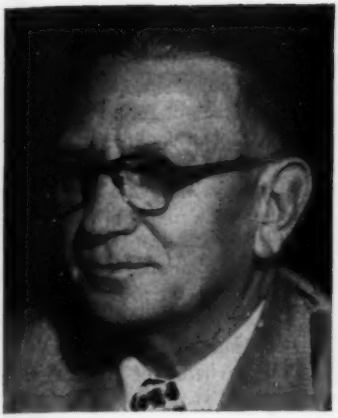
The medical men gave two specific reasons for their refusal to accept a service-type* fee program:

1. A full-payment schedule would compensate doctors inadequately for complicated cases; and

2. Patients would tend to seek unnecessary hospitalization and otherwise abuse the plan if they didn't have to pay *something* out of their own pockets.

Thus the first meeting of labor and medical leaders got nowhere. And the situation became even more difficult as labor pressure—and labor power—increased. On Aug. 30 (following a four-day strike) the Fire-

*In Ohio, medical-surgical coverage is written only on an indemnity basis. Doctors there have never agreed to the service-type Blue Shield contracts endorsed by physicians in most other states.



Dr. Earl W. Burgner

Dr. Millard C. Beyer

MEDICAL LEADERS: "We'll talk to workers—not professional negotiators."

stone Tire and Rubber Company reluctantly negotiated a contract much like the one U.S. Rubber had accepted months earlier. Goodrich and Goodyear soon followed suit.

By Oct. 1, the bulk of the rubber industry was covered by the new health program. The policies were for the most part identical; they differed chiefly in the choice of insurer. (U.S. Rubber had picked Blue Cross-Blue Shield; the other firms had selected private insurance companies: Equitable, Aetna, Prudential.)

Half a City Insured

By last fall some 150,000 Akron residents—more than half the city's population—were covered by the program. The union was assured of heavy support as it got set to push its payment-in-full campaign.

As its first step, it launched a series of newspaper advertisements urging Summit County doctors to seize the "opportunity to render a more complete service to the citizens of this community." Payments provided under the new program, said the ads, "are generous and should cover completely the overwhelming majority of surgical operations."

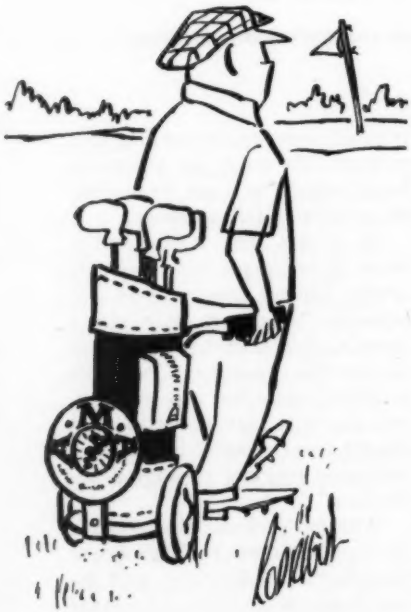
With its "generous" fee schedule thus publicized, the plan spread even further. Before long, with the enrollment of Goodyear Aircraft

workers and certain non-union employes, three-quarters of the city's population had been brought under the umbrella.

Relations Break Off

In December, the doctors and union chiefs got together again—this time at a luncheon paid for by the medical society. Once more, they couldn't come to terms. There have been no further meetings.

The lack of agreement is illustrated by these two statements from spokesmen for the opposing camps:



Says Dr. Beyer: "The union suggested that four of their members hold another meeting with four of ours. We told them we would like to meet with four rubber workers—not four professional negotiators."

Says George Bass, the union's special representative assigned to company-wide negotiations: "The doctors were damned indifferent. We made it plain that we wanted to cooperate with them. But there was no indication that they were willing to accept *any* kind of program."

That's where the doctor-union dispute still stands. Meanwhile, the insurance program has long since gone into effect. Akron's M.D.s treat patients as they always have, and they get insurance checks for the amounts called for in the fee schedules. They may make extra charges, if they want, of course. But labor's demand for full coverage persists—and swells.

Have Fees Gone Up?

One often repeated union complaint: "Doctors are gouging the public." Labor leaders claim, for example, that medical fees in the area have gone up 300 per cent since 1939. The physicians reply that a recent survey indicates only a 17 per cent rise in the same period. (Disinterested observers raise their eyebrows at both figures.)

The union has also worked overtime to defend its controversial fee schedule. It claims, for example, that "doctors in twenty-seven states

have agreed to accept similar fees as full payment for their services."

It often refers, too, to its "$250 surgical schedule." The obvious implication here is that the $250 allowance is the rule rather than the exception. But only a few surgical procedures—gastrectomies and bilateral radical mastectomies, for instance—command this maximum allowance.

'It's Half-Adequate'

Medical leaders, on the other hand, insist that the fee schedule is far less generous than the labor leaders claim it is. As Dr. Earl W. Burgner, the current society president, puts it:

"Before the insurance went into effect, a competent surgeon charged about $60 for a typical tonsillectomy. The insurance pays $30. This has given rise to the absurd claim that we've doubled our fees. The truth is that the fee schedule is only half-adequate."

The same thing holds true in obstetrical cases, Dr. Burgner contends. The insurance allowance for an uncomplicated OB case is $75; but the average fee for such cases runs between $100 and $150.

Dr. Burgner's predecessor, Dr. Beyer, adds that "we've asked the rubber workers for concrete evidence that fees have gone up, but they haven't been able to bring a single case to our attention." Nor has the society's mediation committee received "a single beef" that local physicians are profiteering under the new prepayment plan.

In Dr. Beyer's opinion: "What the rubber workers failed to get in negotiations, they're asking us to give them."

The conflict has been sharpened, meanwhile, by the Akron hospital situation. Overcrowding has long plagued the city's four major institutions; but most authorities agree that conditions have worsened since the health program went into effect.

Hospital Abuse

"It's hard enough to get emergencies into a hospital these days. It's even harder to get a patient out once he's in," says Dr. Beyer.

He blames much of the overcrowding on the fact that—so far, at least—the health plan covers practically all hospital expenses. And he cites case after case in which patients have insisted on unnecessary X-rays and other procedures.

The trouble is, he points out, that a rise in hospital occupancy "may not mean that more people are getting medical care. It *may* mean that people are staying in hospitals longer than they need to."

The unions seem far less concerned than the M.D.s about hospital waiting lists. It's hospital *costs* that apparently worry them. Says U.R.W. Vice President Childs: "We can't help wondering, when we see hospitals substantially increasing their rates for certain services immediately after such services have

been covered by newly written insurance programs."

Back in 1948, he recalls, Akron hospitals were charging $1 a day for boarding newborn babies. In 1951, the prevailing nursery charge rose to $3. Shortly thereafter, Blue Cross contracts were revised to cover nursery care.

"Within a few months of that announced change," he says, "nursery care rates were raised to $5 a day. And by the end of 1952, they were raised still further, to $7 a day.

"Perhaps this was merely coincidence," he observes wryly. "But there is a growing feeling among many of our members that any increase in hospital benefits merely brings on an increase in hospital rates."

But why should skyrocketing hospital costs concern the workers? Their hospital expenses, after all, are fully covered under the new employer-financed health program. True, says one union official; but "we still feel a strong responsibility to the community in seeing to it that hospital charges are kept reasonable for everyone."

It's possible, too, that there's a touch of self-interest mixed in with the union's announced sense of civic responsibility. "In the past," adds this same labor leader, " as hospital rates increased, workers were required to purchase additional insurance to help cover their bills." Labor clearly wants to avoid a repetition of this sort of thing.

Many Akron physicians see a warning for the future in the union's single-mindedness. They're certain that labor intends to push its campaign for "complete" health protection. And they can't help wondering just what form each new demand will take.

As a starter, some doctors believe, the union will try to persuade individual practitioners to accept insurance allowances as full payment in all cases. If the labor leaders aren't satisfied with the results of such "persuasion," they can be expected to make new demands the next time collective-bargaining time rolls around.

They might, for example, ask management to pay for a more comprehensive type of insurance (perhaps with a more generous fee schedule). Or they might even decide to scrap the insurance idea in favor of a union-run health center.

'You Always Ask More'

Naturally, Akron's doctors would not object to a higher fee schedule; but this alternative would certainly be resisted by the employers who foot the insurance bill. Furthermore, labor seems convinced that M.D.s will levy extra charges no matter what the schedule.

Joseph Childs is adamant on this point. He cites experiences with previous fee schedules:

"A $150 operation schedule left an employe with a $25 to $50 doctor bill. We're finding that the $250

schedule still falls short of meeting the doctor's charge. Apparently, what we have been doing in the past several years by increasing surgical fee allowances is raising medical incomes and not increasing protection for our members."

So there's at least an outside chance that the health-center idea may come to dominate union thinking.

Already, Childs himself has cited the need for a "more integrated" health program, to cover preventive and diagnostic care. And in recent testimony before the House Committee on Interstate and Foreign Commerce, he spoke glowingly of two closed-panel plans: the Endicott-Johnson Company plan in Binghamton, N. Y., and the Kaiser Foundation program.

He seemed unmoved by medicine's objections to such plans. What impressed him, apparently, was their cost: Both Endicott-Johnson and Kaiser, he told the committee, provide complete protection for little more than the rubber companies now spend for partial coverage.

It's natural for the Akron physician to feel apprehensive in the face of statements like this one. It's natural for him to wonder how many patients he'll have left if the union continues to think in such terms.

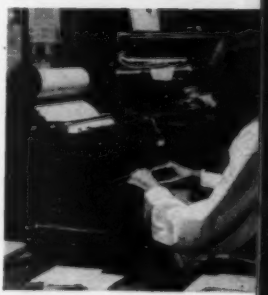
END

"Is the doctor in?"

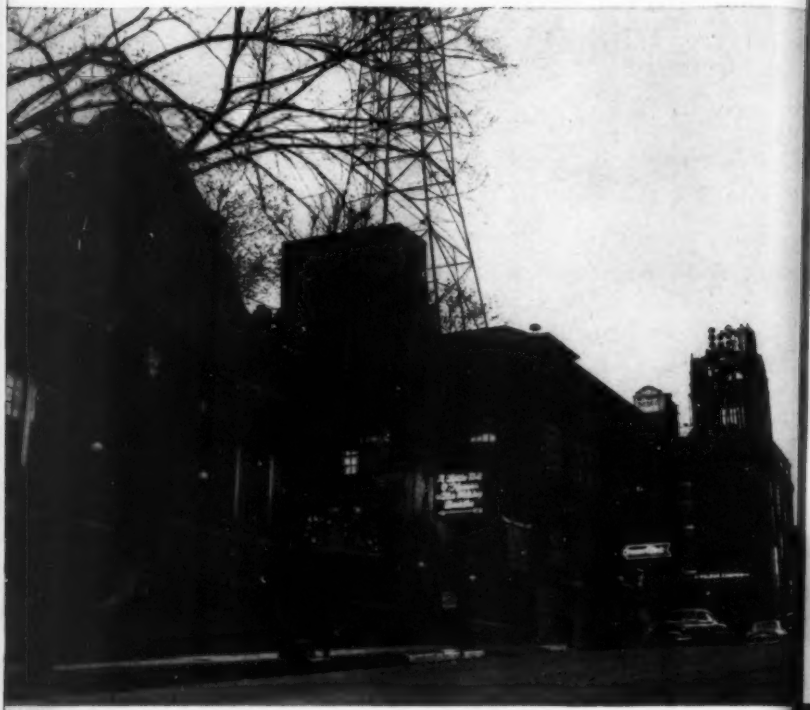
A Visit With B. J. Palmer

What manner of man is the Master Manipulator? To find out, this intrepid reporter invaded chiropractic's nerve center and brought back a tingling portrait

By Carle Hodge



● In the eyes of the drugless, or "straight," cult of chiropractors, Benjamin Joshua Palmer, a chunky, bearded Iowan of 73, is a prophet of the caliber of John the Baptist, whom he faintly resembles. However, unlike the Biblical martyr, the King of Chiro has kept his head. He has also piled up considerable earthly riches, employing methods not unlike those used by another



latter-day prophet—P. T. Barnum.

For B. J. Palmer runs more than the clinic and school of chiropractic that his father, the first chiropractor, founded in Davenport, Iowa. Starting with that spiny legacy, B. J. has gone on to develop and manipulate an empire that includes radio and television stations, a printing plant, a chiropractic equipment factory, an experimental 3D movie process, and what is billed as the largest circus bandwagon in the world.

But what's the Great Adjuster like personally? A good many M.D.s, striving to improve medicine's techniques and ethics, have long wondered. So, recently, I decided to get the answer—by bearding B. J. Palmer in his Davenport den. [MORE→

GIANT RADIO TOWER broods over Palmer's home, clinic, and school [◀], dwarfing man-size bust of his father, the cult's founder [▲]. B. J. says his radio-TV station [▼] never propagandizes for chiropractic.

SLOGANS AND PORTRAITS OF B. J. fill almost every square inch of space on the Palmer school's walls, fences, and stairwells. There are thousands of slogans altogether—most of them written by B. J.

I called him from Chicago and made all the arrangements with a secretary. Her voice became purest honey when I explained that, as a magazine writer, I was interested in doing an article presenting B. J. to a national audience. Two evenings later, I boarded a plane for Davenport and an interview with the man himself.

The bellhop who showed me to my hotel room asked me what business had brought me to town. When I said I'd come to see B. J., he gave me the respectful smile usually reserved for dollar tippers. "The night clerk and three of us bellhops are studying chiropractic," he said.

"You'll like B. J.," added the kid, who couldn't have been more than 18. "He's quite a character. Make sure he shows you the bone museum."

"I'll remember that," I promised. "How come you're making a career out of adjusting?"

The Earnest Bellhop

His grin vanished. In a hushed voice, he explained that his dying grandmother had been saved by a chiropractor. "I've seen the results," he said. The speech had everything but organ music.

That night, I found out why the hotel employed chiropractic students. My bed felt almost as hard as an adjusting table.

In the morning, I took a stiff walk along a half-dozen blocks of tree-lined Brady Street, sloping up from the Mississippi River, to the cluster of nine Palmer buildings. I could see, looming over them, the tower of B. J.'s radio-television station WOC (he also owns WHO in Des Moines). A neon sign told me that this was the "Palmer Campus." And a banner headline on the wall announced that "The More You Tell, The Quicker You Sell." I knew I'd arrived.

Palmer's home, next door to the school, turned out to be an unprepossessing old mansion. A secretary led me through a little of it and deposited me at the entrance to the living room—if that's what I should call it.

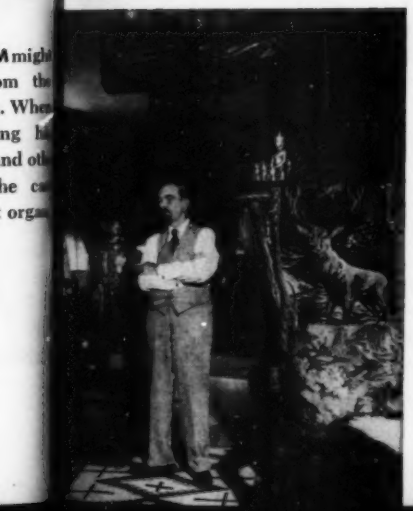
B. J. in His Den

Jampacked between a ceiling of woven tree branches and a floor littered with Navajo rugs, was the maddest collection of good art, sheer trivia, and utter junk I'd seen in a lifetime. I might have been about to meet one of the Collyer brothers; but it was B. J. Palmer, all right, who bounced up from the couch where he'd been sprawled (taking all sorts of chances with his back).

My host could see I was fascinated by the room, so he let me gawk. He pointed out an enormous cloisonne vase ("largest in the world"), the head of a six-point elk he'd bagged in Manitoba, a matched pair of Chinese Foo dogs, and an oversize urn ("made for a Japanese emperor 3,000 years ago and insured for $100,000").

[MORE→

PALMER'S LIVING ROOM migh
have come straight from the
Collyer brothers' mansion. Whe
B. J. tires of inspecting hi
carved ebony tree trunk and oth
er prized possessions, he ca
watch TV or meditate at organ



"I like Oriental things," he said, "because the Orient is the cradle of civilization. I'm not interested in the Rembrandts, the Venetian painters." That took care of them.

He motioned me to a chair. "Call me B.J.," he said. "I want everybody to call me B. J." His voice was deep and resonant, the kind that radio commentators try to cultivate for world's-end announcements.

He told me he'd been up since 5 A.M., as usual, and had already put in some time at his specially equipped typewriter. He showed it to me. It had been fitted with a whopping roll of typing paper so that B. J. never need stop in the middle of a thought to change sheets.

Thanks, perhaps, to this endless flow of what it takes to write on, B. J. is as prolific an author as Mickey Spillane. He said he's currently at work on his thirty-third book; but he wouldn't discuss it—"not until it's done." Not all of B. J.'s works concern chiropractic, by the way. In addition, there are books of B. J. philosophy, B. J. homilies, and B. J. travel notes ("Around the World With B. J.," to mention one example).

I marveled openly at his literary output and at his typewriter. He hastened to point out that he's also the inventor of the "electroencephaloneuromentimpograph," which "measures the quantity of flow of nerve force."

I looked blank. [MORE→

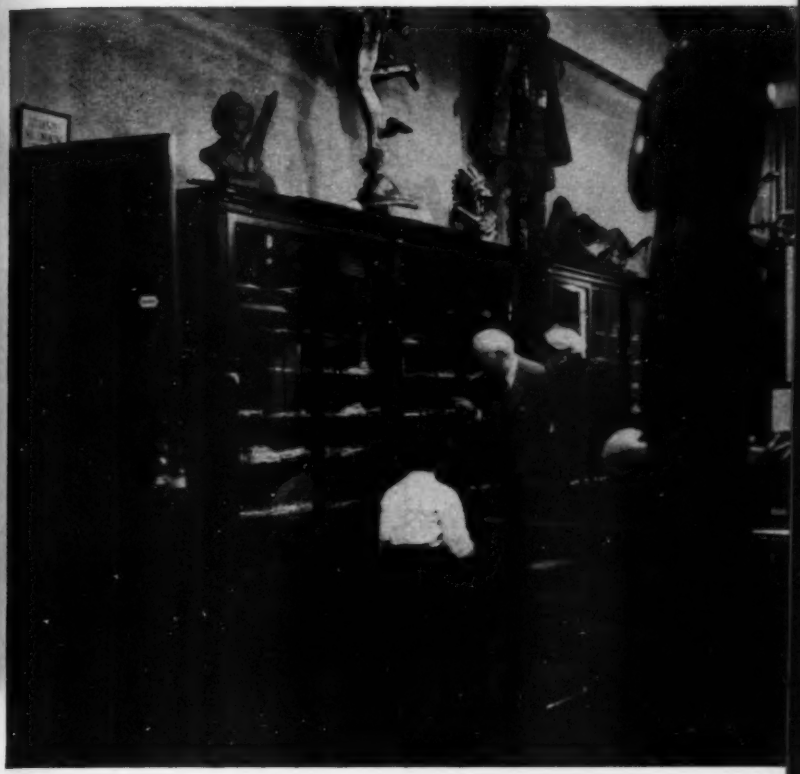
IN 'OSTEOLOGICAL LABORATORY,' nude statues vie for attention with shrunken skulls, skeletons, the overflow from B. J.'s Oriental art collection—and boneless odds and ends like a New Mexican flag.

"It works on the thermopile principle," B. J. explained.

"Oh," I said.

This seemed as good a time as any to discuss B. J.'s theories about disease. So I tried a backing-in tack. "What about fluoridation of water?" I asked. "I hear you oppose it."

B. J. snorted and gave me two seconds' worth of steely blue eyes before answering. "That's just another experiment in how to keep people well by making them sick," he said.



B. J.'s stand on fluoridation, I found, parallels his thinking on chlorination. "It's bad stuff," he said. "We have our *own* well here at the school. It pumps up 200 gallons a minute. *Pure* water."

Incidentally, this undoctored well water is a fairly profitable little sideline for the Dean of Davenport. He sells it at ten cents a bottle so that chlorinated water need never contaminate the throats of Palmer devotees.

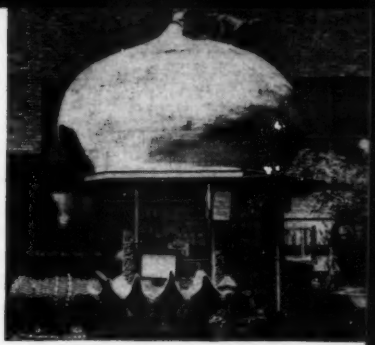
B. J. enlarged on the subject. "I

won't drink anything but raw milk," he told me. "They won't let anybody sell it here in Davenport, but that's all right. I send out to the farm for mine. The cows know best how to give good milk. When you boil it, you just boil the germs. As if *they* cared!"

"Speaking of germs . . ." I began again. But my prompting was interrupted. B. J. glanced at his watch, announced that it was almost 9:30, and lighted a cigar. "I have to address some alumni in five minutes," he said. "Like to come along?"

He led me briskly out of the house and down the street to the school. Passers-by greeted him with "Hello, B. J.," or "Morning, B. J." Some he favored with a pleasant, businesslike "Good morning, Doctor." Others got a hearty back-slap from the Palmer palm.

The first thing that struck me when we entered the main school building was the array of epigrams and slogans on the walls. They were everywhere—covering almost every



1,500,000 VISITORS have marveled at B. J.'s garden spot, "A Little Bit o' Heaven." On display here are such wonders as a wishing Buddha, a Russian kiosk, a statue-clogged hothouse—and a bench inviting viewers to "Sit and ponder what it's all about."

inch of space—even to the staircase risers and the elevator shaft.

"M.D. Means More Dope," I read. "M.D. Means More Deaths—D.C. Means Disease Cured." "The World Is Full of Hypocrites Who Have Never Fooled Anyone."

"I wrote most of them myself," announced B. J., with understandable pride. "An empty wall space is space that doesn't work," he added. I felt sure that *that* slogan, too, was on a wall somewhere.

The Chief of the Chiros must

have felt right at home in the huge classroom where he addressed the old grads. For there were no chairs—just adjusting tables. I hopped up on one and joined the audience. Between the hotel and this, I was finding precious little comfort in Davenport.

B. J.'s listeners, mostly in shirt sleeves, paid close attention as he read a prepared speech on "How To Get the Most Out of Your 'Think Tank.'" Here and there, he made a passing reference to chiropractic, but he didn't beat it dead.

As we walked out of the classroom, applause rolling after us, B. J. asked if I'd enjoyed the speech. "It was fine," I told him.

"Then you'd like my others, too," he said "I have a hundred of them. I wrote most of them in Florida—at Sarasota, where I spend the winters. I like to be near the circus."

Who Wrote Shakespeare?

It's no coincidence, he added, that he doesn't stress chiropractic in his speeches. "I address a lot of nonchiropractic groups, you know. And in my speeches, I never refer to my profession or to any of my other businesses at all."

His most popular speech, B. J. allows, is one called "Selling Yourself." "I've given it maybe 5,000 times," he said. "Rotary clubs love it."

But, in a confidential tone, he added, "Frankly, I'm a bit tired of 'Selling Yourself.' So I'm replacing it with two new ones: 'Who Wrote Shakespeare?' (Bacon did, you know) and 'The Greatest Mystery in History' (that's about the lost Cambodian civilization; I looked into it when I explored Angkor Thom)."

We stopped for a moment before a bust of B. J.'s father, D. D., the one-time magnetic healer who'd launched all this. D.D. died in 1913, and his ashes are there beneath the bust. We were silent for a moment. Then I told B. J. I'd like to see the bone museum.

He wagged a finger at me, flashed his blue eyes, and said: "Please! The osteological laboratory." The bellhop hadn't told me.

Collector's Items

Well, it turned out to be more than a collection of old bones, at that. Some of the overflow from B. J.'s living room had got in, too. There were some Oriental odds and ends and sundry items like a New Mexico State flag and an Egyptian mummy known as "The Princess."

Our next stop was a garden spot called "Little Bit o' Heaven," that contains the prize display of Palmer acquisitions. This, B. J. told me, had begun originally as a "simple" greenhouse to store his collection of exotic plants. It "just grew and grew" till it became the only heaven on earth that may be entered on payment of a 51 cent admission fee. (B. J. let me in free.)

As I gazed in wonderment at

such celestial objects as stone monkeys, bells, fish, a lotus pool, Hindu idols, and a Russian kiosk (with postcards for sale), B. J. explained: "I enjoy doing things that other people don't want to do." With that, he gave one of the exhibits an affectionate pat. "The two largest known giant clam shells in the world," he said matter-of-factly.

As we walked back to his house, B. J. told me that after he'd finished high school he decided to join his father, to study the human spine, and to grow a beard. "I wanted to be above the crowd," he said. "There has never been a razor on my chin."

I asked him about his son David, who's now 47. Would they pose together for a picture? For the first time, I encountered a freeze. "That's one thing I won't do," B. J. snapped. "My son isn't interested in this business."

David, I learned later, sticks pretty much to his farm and doesn't always react with enthusiasm to B. J.'s Davenport enterprises. This lack of rapprochement between father and son may also stem from the fact that B. J.'s late wife controlled most of the Palmer empire and willed it to David's two daughters, with B. J. and David as executors.

B. J.'s Faction

Though B. J. declined to discuss his family problems, he talked quite freely about what he called "differences within the profession."

The fact is that B. J. heads only one of two major chiropractic factions. He's president of the International Chiropractors Association (and also its landlord, since it rents space in the Palmer schoolhouse). The I.C.A. insists that D.C.s should do nothing but adjustments. It firmly opposes the use of drugs. So it has no use whatever for medical men.

The opposition faction is the National Chiropractic Association, with headquarters in Webster City, Iowa. The N.C.A. scoffs at the I.C.A. as a one-man show. It countenances physiotherapy by chiropractors and drug therapy by M.D.s It refuses to maintain that all medical men come equipped with horns.

"Our ranks are divided," Palmer told me, "because of the weak sisters." He paused and shook his head sadly. He didn't mention that his own association numbers only about 2,000 members, while the "weak-sister" N.C.A. has some 8,000.

Spoiling for a Fight

"There are a few chiropractors who want to back into medicine and become what I call bastardized physicians," he said. "And it's a shame. We have so much good here that we should stand up and fight the M.D.s, not try to join them."

Just in case I had any doubts about his willingness to fight, he reeled off a couple of tales about brushes he's had with physicians in the past: [MORE→

"Some years ago," he said, "an A.M.A. leader spoke in Davenport on 'No Spit—No Consumption.' His theme was that people get TB because other people expectorate. I stood up at the end of his talk and said I'd like to ask a question. He didn't know who I was, but he looked at my beard and said, 'Yes, Doctor?'

"I said, 'I take it from what you say that Adam must have had consumption, because he was the first man to spit.' The A.M.A. man agreed it was possible. 'But that couldn't be true, Doctor,' I told him, 'because there was no one to spit *before* Adam.' The audience roared; and I walked out."

B. J. Incognito

Another triumph for B. J. occurred on a train ride from Davenport to Chicago. He was sitting in the parlor car, reading a medical journal. So was the man in the next seat. Here's what happened, in B. J.'s words:

"He asked me if I was a doctor. I said I was. I asked him. He was, too. When I told him I came from Davenport, he said, 'Oh, that's where all those chiropractors are, isn't it? Say, what do you think of those fellows?'

"'A lot of people think they do a lot of good,' I replied. 'Now, you and I know that if you relieve pressure on the spine so that the nerve force can flow, it clears up a lot of things. Chiropractic is simply an adjustment of interference, a correction of the resistance force.'

"The M.D. was nodding his head in agreement as I spoke. I continued. I said: 'The energy of the body is made by the brain, and every organ of the body runs from it. The energy flows through the spinal cord and branches out to every muscle. But man, in his desire to do more than he's physically capable of, stops the nerve force from getting through—and that's the cause of disease.'

He Stalked Out

"Well, this M.D., kept right on agreeing—even when I pointed out that it's a terrible condemnation of systematized medicine that in all its 5,000 years it hasn't yet found the cause of polio or cancer.

"Finally, we reached Chicago. I handed him my card. He looked at it and stalked out of the car. Didn't even say good-by."

B. J. laughed heartily.

It was now time for *me* to bid B. J. good-by—which I did. Looking at my watch, I figured that if I hurried lunch, I could catch a plane to Chicago in time to get a comfortable bed that night.

The bellhop stopped me in the hotel corridor. "How'd you like B. J.?" he asked.

"He's great," I said. "And I loved the osteological laboratory."

He looked quizzical for a moment, then grinned appreciatively. "Oh yeah. I almost forgot!" END

What Do Doctors Think About Blue Shield?

Though solidly behind the program, many M.D.s feel that it doesn't pay enough, it's needlessly geared to the specialist, and—above all—it inadequately explains contracts to patients

By William Alan Richardson

● "What, if anything, do you think is wrong with Blue Shield—and what do you think should be done about it?" We asked this question recently of some 1,500 M.D.s in all parts of the country.

The overwhelming majority of the answers that came pouring in expressed strong approval of the plans and their aims. Evidently, doctors everywhere believe in Blue Shield and have high hopes for its future. For example:

¶ A doctor in Louisville, Ky., says: "I have no complaints whatever. I think Blue Shield is doing an excellent job. I just hope it's able to continue."

¶ "It has been a godsend to my patients," writes a Washington, D.C., physician. "I honestly have no criticism."

¶ "No plan is perfect," a Fresno, Calif., M.D. declares, "but there's nothing wrong with Blue Shield that study and experience can't correct."

There were scores of such bouquets. Even though invited to assay Blue Shield frankly (and anonymously),

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**This article approximates a talk by Mr. Richardson, editor of* MEDICAL ECONOMICS, *before the 1954 Conference of Blue Shield Medical Care Plans.*

a great many practitioners had little or nothing unfavorable to say.

But there were brickbats, too. And the brickbats are perhaps more interesting, because they may point the way to constructive changes.

We quickly discovered that—apart from the fairly general and obvious complaint of "too much paper work"—the criticisms break down into three main categories:

1. Blue Shield doesn't pay the doctors enough.

2. Certain types of doctors (e.g., general practitioners and internists) are discriminated against.

3. Patients too often believe their contracts cover conditions that actually aren't covered.

Biggest Sore Spot

This last point is by all odds the number one sore spot; more doctors mention it than all the rest put together. Typical comments:

¶ "Blue Shield is advertised as 'The Doctors' Plan.' So we doctors have a stake in seeing that it doesn't give anyone a false feeling of security.

"Medical men oppose socialized medicine, and they tell the public to rely on voluntary health insurance. Yet every time such insurance fails a patient (not because of any fault in the insurance as such, but because the patient didn't know what it excluded), he becomes a potential flag-waver for socialized medicine."

¶ From New England: "Services that are not covered should be explained. Last winter, a patient of mine stumbled and injured his wrist. There was no fracture. I applied a wrist bandage. Later, my bill was repudiated by Blue Shield, as was the roentgenologist's, on the ground that no fracture was reduced.

"Blue Shield asked, in reply to my complaint, what kind of bandage had been used. I told them an elastic bandage. Again they refused to settle. Finally, it came out that if an adhesive bandage had been used, they would have paid my bill."

Doctor Gets Blamed

Another man, speaking of a patient who had a strangulated femoral hernia, says: "Because the woman had been a subscriber for less than a year, the policy didn't cover her condition, and *I* had to share the blame. I don't maintain that the policy *should* have covered her; but when she first became a policyholder, she ought to have been made to understand what she would—and would not—be protected against.

"It isn't enough to say, 'Let the buyer beware!' Blue Shield is a public service; its obligations go far beyond those of a commercial carrier."

An M.D. in Buffalo, N.Y., cites a policy that failed to cover a premature delivery, even though the delivery would have been covered if it had not been premature. "The patient," he says, "never dreamed she would have to meet the bill out of her family's meager resources."

He adds: "I know of another case—a man—who was hospitalized re-

cently in his home state. He paid about $600 more than he would have paid if hospitalized in the state where he worked. This man believed mistakenly that he was covered equally, no matter where he might receive care. He has now concluded that he was 'taken'—and that his contract is the product of a near-racket.

"True, the loss in this case was on a Blue Cross contract—not on one written by Blue Shield. But it still illustrates the importance of telling the subscriber what his policy excludes."

How to Lose Friends

Often the doctor's explanation to the patient that there's going to be an additional charge is the spark that touches off an explosion.

A Longmont, Colo., M.D. says: "Many a patient is led by the individual who sells him Blue Shield to believe that the contract will take care of everything. When this proves untrue—for example, when some doctor legitimately bills him extra for services rendered—the patient immediately takes it out on the doctor, not on Blue Shield!"

"Time and again," says a Janesville, Wis., physician, "a patient comes into my office for a routine visit, and on the way out airily brushes off my fee with the remark, 'Oh, I have insurance.' If I explain that his insurance doesn't cover that kind of office call, he invariably gives me a piece of his mind. Blue Shield ought to set up complaint centers to help iron out such disputes."

Finally, a comment in the same vein from a Long Island physician: "Let Blue Shield give the patient as much educational information and literature as it gives the physician. And let the exclusions be shown in words of one syllable, printed boldly in red ink."

Fees Are Too Low

The fact that some doctors say Blue Shield doesn't pay them enough is scarcely cause for surprise. (Who *does* think he's paid enough?) The real surprise, to many, will be the fact that this complaint ranked second, instead of first, in frequency.

Here's how one Detroit surgeon puts the case: "Blue Shield fee schedules ought to be revised at regular, frequent intervals. They ought to be brought up-to-date and in line with the increased cost of living."

Several other doctors suggest that the schedules be tied *directly* to the cost-of-living index.

Says a G.P. in Aliquippa, Pa.: "The tendency is to coddle patients on the one hand and to exploit M.D.s on the other. Let Blue Shield keep in mind that doctors eat, too."

"Suppose," another Pennsylvanian writes, "that a G.P. has been attending a patient in labor for twenty hours and then finds he needs an obstetrician's help in completing the delivery. Blue Shield in this area pays only $60 for the entire procedure. This is absurdly inadequate

compensation for two physicians faced with a complicated delivery."

Several doctors take a more cheerful view, however. Says one: "Maybe Blue Shield fees aren't, in some cases, up to the general inflated level of prices. But one thing helps to compensate for this: Since payment is usually prompt, repeated billing isn't necessary."

Unfair to Some M.D.s?

Blue Shield "discrimination" against general practitioners, internists, and others is the next most frequent complaint on the over-all grievance list.

"*My* biggest gripe about the plan is its failure to pay the fee of internists," says a San Diego, Calif., practitioner. "Prolonged negotiations in this state have resulted in a total stalemate. As long as this condition exists, I find myself unable to support Blue Shield constructively in any way."

From a Wisconsin M.D.: "Fees for diagnosticians are so small as to be ridiculous. Yet the skill required of such a man is certainly equal to that called for in a surgeon who does, say, a bowel resection."

A Kentuckian says he thinks Blue Shield does an excellent job—but that it's derelict in not paying medical men who assist in surgery. "Our local hospital has no house staff," he writes. "So it's usually up to the referring physician to act as assistant to the surgeon. This is no great pleasure for the referrer; but our hospital regulations require an assistant at all major surgery. So there isn't much choice. Benefits should be increased so that the assistant could be paid. Or he should get a percentage of the operating fee."

Other Criticisms

Of the other complaints leveled at the Blue Shield program, a few seem worth discussing briefly here. Take the rural doctor's point of view, for instance:

Most physicians with country practices feel that Blue Shield is great as far as it goes, but that in the rural areas it doesn't go far enough. Writes a Delta, Utah, G.P.: "I'm in a country district where few people have either Blue Cross or Blue Shield or equivalent protection. If such coverage were available, I'm sure many would buy it. We need a better system of distributing voluntary health insurance to the general public."

Blue Shield also needs to make some provision for catastrophic coverage, say many of the doctors. One man puts it this way:

"Most families can manage the small medical bills. But it's a different story when the breadwinner is laid up for six months with a broken leg. I would like to see a type of deductible insurance in which all medical bills of any kind are paid in excess of a certain amount—say $200. Then a family could budget for medical care just as it now budgets for groceries."

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Here's an even more forceful statement of the same idea:

"I had thought that the Eisenhower reinsurance plan would stimulate the initiation of catastrophic coverage. But now the insurance companies say they don't need reinsurance. What *do* they need to stimulate them to make such protection available generally—a kick in the pants by another Oscar Ewing?"

It's significant, in fact, that so many physicians are making a real effort to consider the health problem from the patient's point of view. In speaking of the comparatively high cost of health insurance coverage for low-income families, for example, a California doctor asks this question:

FIRST WOMAN to serve as a Regular Army doctor, Capt. Fae Adams of California finds her relaxation—as many a male M.D. does—on the golf course.

Bars on Her Shoulders

By Edwin N. Perrin

● Once upon a time the Medical Corps of the Regular Army was an exclusively male preserve. The doctors were all men, and they lived in a masculine atmosphere. Their locker room, for example, at a big Army base like Washington's Walter Reed Hospital resembled that of a good golf club.

But that's all been changed now. Now there's a feminine touch. Part of the dressing room at Walter Reed is hung with skirts and blouses. This part is for the private use of the Regular Army's first woman doctor, Capt. Fae Adams of San Jose, Calif. She's a slim brunette in her early thirties, unmarried, a rancher's

"Would preferred-risk policies be practical? Could a subscriber's Blue Shield premiums be reduced in inverse proportion to his claims during the previous year? Anything that tended to reduce the number of small claims would tend also to lower premium costs."

To sum up, then: There *is* a good deal of criticism, but most of it is constructive and thought-provoking. And medical men in general are solidly behind Blue Shield, in spite of what they see as its faults.

A New Mexico physician sums up in these words: "If any doctor ever did think of selling Blue Shield short, he might well pause to consider how tough practice would be today without it." END

---

daughter, and an avid golf player.

Dr. Adams has already seen more military service than most M.D.s get in a lifetime. During World War II she enlisted as a private in the Women's Army Corps, became a ballistics expert at Aberdeen Proving Grounds, and ended up on Okinawa as a second lieutenant in the wartime physical therapy program.

But physical therapy kept reminding Dr. Adams of her childhood ambition to become an M.D. (She'd gotten as far as the third year of pre-med before her money ran out.)

Finally in 1947 she took a discharge from the Army—and, with practically unlimited rights under the G.I. Bill, headed for the Woman's Medical College of Philadelphia.

Five years later she emerged with a completed interneship, an interest in obstetrics, and scant funds for advanced study. Result: She went back to the Army. Now, as a Captain in the Regular Medical Corps, she's a military resident in Ob./Gyn. at Walter Reed.

Her sex apparently gets Dr. Adams few special privileges from the Army (aside from her private dressing room at the hospital).

Before her present assignment, she put in a tour of troop duty at Camp Crowder, Mo. The job, she says cheerfully, included inspection of the guardhouse, full responsibility for sick call with male troops, and treatment of all the diseases to which men are heir. And the soldiers seemed perfectly willing to be treated by a woman doctor, she insists.

Will Captain Adams make the Army a career? Almost certainly. She loves to travel, and when she's finished her three years of training at Walter Reed, she'll probably begin the first of what she hopes will be a long series of overseas assignments. As for quitting to get married, the most she'll admit is that it's "not utterly impossible." END

Jottings From A Doctor's Notebook

By Martin O. Gannett, M.D.

● Ten years ago Dr. Bisma gave up general practice to devote himself to a new enthusiasm: geriatrics. His competence and zest have since brought him a prosperous practice in the new specialty—but at a price.

In the academy lobby, weary after a day of ministering to querulous septuagenarians, he inhales deeply from his pungent cigar and says:

"I've been thinking that soon my wheel will turn full cycle. Another year or two, and so many of my patients will be in their second childhood that I'll be practicing pediatrics again . . ."

* * *

Although the hospital administrators did not have the matter in their plans when they budgeted the internes' food allotment at 93 cents a day, they did thereby assure the hospital a safe reserve of donors' blood for transfusions.

The constitution of The Internes' Blood-Money and Hamburger Association, Inc., formed a year ago and still flourishing, provides that members serve in turn as blood donors, the proceeds to be expended on supplementary meals at Nick the Greek's.

Only members may participate, with the single exception of a standing invitation to Superintendent Krall, which the latter has not yet accepted.

* * *

It happened back in medical school: The disturbingly beautiful Jean Cattell had for almost two years kept a

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hundred male classmates in a state of wishful and frustrated exophthalmos.

One day, while the second-year class practiced the technique of the complement-fixation test by doing their own Wassermanns, Student John Horsley decided on a punishment to fit the crime of Jean's inaccessibility.

While he lured her to the window with small-talk, a fellow-plotter was to add some of the known positive serum to Jean's tube. John then waited in suppressed glee to enjoy the victim's agony.

But the agony was all his: His own tube, too, showed a four-plus reaction.

Jean smiled at him consolingly: "I imagine I got mine from you, John. But where did you get yours?"

* * *

For Tom Jerome's numerous aches and pains, a disguised aspirin tablet twice a day has for a whole week worked a complete cure. A week is a long time to go without symptoms. During rounds today, Tom speaks up: "Say, Doctor, you know them white pills the nurse gives me? I wish you'd make her stop. They give me a headache, and I have to get up and take some aspirins to get rid of it . . ."

* * *

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Is the Family Doctor Obsolete?

By David Landman

MEDICINE has become more skilled, more specialized—and more impersonal. Today's patients too often get lost in what Dr. Walter B. Martin, new A.M.A. president, calls a "mechanical maelstrom." Says he: "They speed from this laboratory to that, from one specialist to another, with hardly a pause for consideration by anyone of their problems as a human being."

There's an obvious cure for this: "Every patient," says Dr. Martin, "should first seek the advice of a general practitioner." This would prevent frustrating runarounds and keep costs down. MEDICAL ECONOMICS *has been advocating it for years.*

Now other magazines are advocating it too. And that's important, because it means that your patients may at last be getting the word. The following article from Cosmopolitan reflects current thought on the subject. We reprint it here by permission, in slightly condensed form, as a matter of interest to both G.P.s and specialists.*

● When the medical history of our times is written, the 1940's and 1950's may be known not for the wonder drugs or the conquest of polio but for the strange disease that threatens to neutralize much of the progress of modern medicine—"infectious specialitis."

As infectious as the common cold, this malady is caught at the bridge table and the hairdresser's, at social gatherings and public places. It afflicts the general public and has even spread to doctors and hospitals.

"Infectious specialitis" is an inflammation of people's minds that makes them think a twenty-five-dollar-a-visit specialist who doesn't know them will automatically cure them five times as fast as the five-dollar doctor who knows them well.

The president of the American Medical Association

recently warned, "The expenditure of money for various useless remedies, and the visiting of one specialist after another without advice and supervision is not only unscientific and unrealistic but lacking in an intelligent approach.

"The general practitioner is the backbone of American medicine."

Nevertheless, between 1940 and 1950, while the population of the country increased by twenty million, we *lost* thirteen per cent of our general practitioners. In some areas, the ranks of the G.P. have been decimated. The G.P. has been belittled by the public, locked out by hospitals, and rejected as a model for medical students. Yet in the opinion of specialists, medical educators, and the medical world generally, the G.P., the family doctor, is the one indispensable man.

She Tried Everybody

A lady in Atlanta who had splitting headaches went to see her eye doctor. "Nothing wrong with your eyes, ma'am," he said. "From the way you describe the pain, maybe it's your sinuses." An otolaryngologist thought her sinuses were all right, but he got a roentgenologist's help to make sure. A dental surgeon said a couple of impacted wisdom teeth might be causing the trouble. They were removed, but the headaches remained. Next the lady went to a neurosurgeon. Could it be a brain tumor? After examining the

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patient and a new set of X-ray negatives, the surgeon said, no tumor, nothing to worry about. He patted her hand reassuringly. Perhaps she ought to see a psychiatrist. The psychiatrist listened to her tearful account. "Before we go any further," he said, "I'd like a report from your family doctor."

The family doctor began the sort of examination that general practitioners have been making for years. In a matter of minutes, he discovered that the woman's blood pressure was high and there was albumin in her urine. He prescribed for her, and the aches disappeared.

The woman feels badly about the $235 in wasted specialist fees. But far worse were the six weeks of needless anguish she endured because she tried to diagnose her own symptoms instead of starting at the beginning—her family doctor.

How It Started

In the late 1920's, medical science began making tremendous advances. Newspapers and magazines told of the wonderful things the specialists were doing. A new frankness in discussing the human body admitted laymen to the medical lingo. People who had never even seen a scalpel could read an article and afterward talk knowingly about gastrectomies and Caesarean sections.

The general practitioner welcomed the new interest. He was aware of his own limitations, and he knew when a patient required a specialist's care and which specialist to call in on the case.

But then people began insisting on seeing the specialist first. They didn't want to be seen by the general practitioner.

Specialist Suffers

As a result, and through no fault of either, both specialist and family doctor suffered. The specialist was seeing a new patient without the valuable background material he would normally receive from the G.P.

As one famous New York specialist explained it: "The relationship of patient to specialist in private practice should be something like that which exists in the diagnostic clinic. A patient goes in for a complete checkup. He doesn't say, 'First I want to go to the orthopedist,' or 'Let's skip the cardiologist.' Proper medical diagnosis and treatment is progressive and co-ordinated. On the basis of the findings of the first physician, the second functions more efficiently. So it is in private practice. Eliminate the general practitioner, and you eliminate the primary step in the diagnosis and treatment of disease. Any good specialist deplores such a trend."

A fairly lighthearted example of what the doctor was talking about concerns a Texas woman from a small city that has excellent medical facilities. She flew all the way to New York for a checkup by an internist mentioned by a friend. The

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woman, who complained she was weak and listless all the time, told her friend at the airport, "I'm going to a real doctor. The kind we got in this town just wouldn't know where to begin." The New York specialist found she was suffering from too much caviar and too many cocktails. She needed to lose twenty-five pounds and get some exercise—facts that would have been obvious to the family doctor, had she asked him.

'I Want Strychnine'

One man walked into the office of an Oregon doctor and demanded a powerful heart medicine loaded with strychnine.

"Wait a minute, John," the doctor said. "First let's listen to your heart." The patient refused. "You're not a heart specialist!" he snapped, and walked out of the office.

Once in a while, a doctor talks back. A man—who wouldn't think of telling his garage repairman how to fix his car—woke his physician one midnight. "The wife's got the grippe. Will you come over and give her a shot of penicillin?"

"You're sure it's the grippe?"

"Yeah, she's had it for three days."

"And she needs a shot of penicillin?"

"Yes."

"All right, friend, you've diagnosed the case and prescribed the medicine. *You* shoot her."

Nevertheless, the G.P. pulled on his clothes and went out to tend the case.

As "specialitis" spread in the

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acid vaginal douche

The vaginal acid reaction is an important factor in preserving the normal vaginal flora and in suppressing the growth of undesirable invaders. It is rational, therefore, to use cleansing and therapeutic applications with an acid pH. Massengill Powder in the standard solution has a pH of 3.5 to 4.5, approximating the acidity of the normal, healthy vagina.

Massengill Powder solution provides a vaginal douche that is cleansing, soothing, deodorizing, and highly useful as an adjunct in the treatment of many pathological conditions of the vaginal tract producing leukorrhea. Because the solution is nonirritating, it can be used for routine feminine hygiene. Its clean, refreshing odor makes Massengill Powder acceptable to the most fastidious patient.

Massengill Powder contains: Boric Acid, Ammonium Alum, Berberine Salt, Phenol, Menthol Isomers, Thymol, Eucalyptol and Aromatics.

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GENEROUS SAMPLE ON REQUEST

Here's a New Advance in Oral Penicillin

A delicious, stable, ready-to-use suspension in teaspoon-dosage form of the ideal oral penicillin

• ***HIGHER BLOOD LEVELS.*** Dramcillin Suspension is a new, stable form of soluble potassium penicillin G—the ideal salt of the antibiotic for oral use. Wright and associates[1] have recently demonstrated that orally administered potassium penicillin G *produces highest blood levels* and *is most reliable and most desirable from the standpoint of uniform absorption* in comparison with insoluble penicillin salts.

• ***MORE PROLONGED EFFECTIVE BLOOD LEVELS.*** Foltz and Schimmel[2] have shown that oral potassium penicillin G when compared with insoluble salts (such as benzethacil), following equal dosages in the same patients—*produces peak levels five times higher* and *yields longer-sustained serum concentrations.*

1940's, it got so that in the better-class suburbs any doctor who called himself "general practitioner" suffered the pangs of an underfed pocketbook or was reduced to applying Band-aids and Unguentine.

One Manhasset, Long Island, family decided they needed a pediatrician for their new baby. They took her seventeen miles to a Park Avenue man in New York for immunization shots. Every time the mother wanted advice on formula or feeding problems, she made a toll call to New York. The night the baby woke up coughing and feverish at three A.M., the family made a frantic appeal to New York. The pediatrician explained over the phone it would take him at least an hour and a half to drive out on a snowy night like this. "Get hold of a physician who lives near you," he advised. Obediently they pulled out the phone book and summoned the G.P. they hadn't seen for almost two years.

"It didn't make sense," the family doctor said later. "The pediatrician treated the child when she was well, but I was supposed to care for her when she was sick!"

Lay Diagnosis

In most cases, the specialists themselves recognize, in the layman's taking it upon himself to decide which specialist he should consult, a dangerous tendency toward self-diagnosis.

A woman in Milwaukee was breathless and hoarse one morning when she talked on the phone with a friend. The friend suggested she see "that wonderful throat specialist who once took care of me!" A week later she saw him. The specialist painstakingly explained it wasn't a throat condition at all; it was a mild coronary attack, and the proper place for her to have gone was her family doctor.

Laymen cannot possibly diagnose their ills correctly. All they can do is tell what hurts. After Bette Davis "died" of a brain tumor in "Dark Victory," the country's brain surgeons found their waiting rooms filled with cases of migraine, eyestrain, and sinusitis.

The Springfield, Massachusetts, man with headaches who took his own short cut to the offices of an ophthalmologist and then a psychiatrist really didn't take a short cut at all. It took the psychiatrist weeks to discover (and most eye doctors never would have found out) what the family doctor knew after the first house call: that the man's mother-in-law sat in a rocking chair in his living room, disapproving of his job, his clothes, his car, his speech, and his standard of living. The man's whole life was a headache.

Was It Snobbery?

It was an uninformed public that started the notion that the family doctor, like the dodo, was ready for the museum shelf. The notion spread to the medical profession itself. Physicians hurried to take the exams

to become orthopedists or gastroenterologists instead of just plain doctors.

Hospitals, too, succumbed. Some shut their doors to patients of G.P.s—you had to be under the care of a specialist. This was partly snobbery, partly a kind of specialists' trade-unionism.

The medical schools were not immune. The top educators had always realized the student-doctor should be taught to look at the whole patient, not at just his liver or his complaints. A few schools encouraged men to become family doctors. But the way most med students saw it, general medicine was horse-and-buggy medicine and they wanted Cadillacs.

In 1941, only one of every ten medical-school seniors planned to enter general practice. Half a dozen years later, a dean reported nineteen of his seniors were going to be brain surgeons, twenty-five were going into internal medicine, and the rest were planning to be otolaryngologists, gynecologists, allergists, or what not. "I'm afraid," he said glumly, "we're not graduating anyone who is going to take care of sick people."

G.P.s Band Together

In June of 1947, 150 family doctors gathered in Atlantic City. "We are not antiquated," they declared, "and we do not intend to fall into disuse." So they organized the American Academy of General Practice to speak up for the family doctor.

The movement spread. Across the country, G.P.s formed state academies and county chapters. They held organizational meetings with the enthusiasm of homecoming football rallies. They held scientific assemblies at which top specialists lectured on new developments, from allergies to zymosis. Their purpose was not to take the place of specialists. Quite the contrary. They recognized that no G.P. could or should attempt to take upon himself the responsibilities of a medical man who has long dedicated himself to the intense exploration of one particular field. What the G.P.s were seeking was more knowledge about these specialized fields and the latest developments in them so they would be able to work most effectively with the specialist in behalf of the patient. Every member had to complete 150 hours of courses every three years—or else get out.

Said one of their officials, "There are 125 different national medical associations, but the G.P.'s organization is the only one that makes a doctor continue to improve his knowledge and skills for the rest of his life."

Now the A.A.G.P. is the country's third-largest medical organization, with nearly 18,000 members who believe they are the key men in modern medicine.

Their program was impressive. "The G.P. stages a comeback," announced the professional journal

Upjohn

For the many thousands of patients with essential hypertension, there is new hope for longer, happier lives. RESERPOID* (Upjohn brand of reserpine) is the active, pure alkaloid of Rauwolfia serpentina. In just 1/1000 mg., Reserpoid matches the potency of 1

*TRADEMARK

mg. of the whole root... Reserpoid carries non-hypnotic sedation and bradycardic action along with its principal antihypertensive effect. It is a persistently pleasant drug: usually even before the pressure falls, a sense of calm settles over the anx-

ious and irritable hypertensive. Lowering of the pressure is gradual, which gives the patient a week or more to adjust to the new levels. Reserpoid acts centrally upon the autonomic nervous system. It is not a ganglionic blocking agent, does not induce

postural hypotension . . . Reserpoid has no presently defined contraindications. It is ideal for the "average" case—that large group of mild and moderate hypertensives who have symptoms, but no demonstrable pathology. In severe hypertension with advancing vas-

cular damage, Reserpoid is valuable in augmenting and stabilizing the effects of other, more drastic drugs—making their smaller dosage possible. Reserpoid therapy is not encumbered by the difficulties of delicate titration. Just 1 mg. of Reserpoid daily, taken in

one to four doses, is the usual initial dosage. Later on, improvement may be maintained on considerably less—sometimes on as little as 0.1 mg. per day. Reserpoid is available in 0.1 mg. and 0.25 mg. scored tablets, in bottles of 100 and 500, at all ℞ pharmacies.

The Upjohn Company, Kalamazoo, Michigan

MEDICAL ECONOMICS. "Three years ago the fortunes of the family doctor scraped bottom. The flood tide of specialism was at its postwar peak. The G.P. was submerged and choking for air." They credited the A.A.G.P. with giving the family doctor "his biggest boost."

Hospitals Bar G.P.s

Not all hospitals were in sympathy. In Miami, where a big, new hospital was under construction in 1950, the governing board decided patients of G.P.s would have to seek hospital care elsewhere. The local A.A.G.P.'s protest was ignored. Family doctors thereupon alerted their patients, "We're not going to be able to take you into this hospital to diagnose and treat you." Some people were outraged. Burning letters of protest made the board see things in a new light, and the hospital decided to add a general-practice section.

Many other hospitals, though not all, do allow G.P.s to do whatever internal medicine, pediatrics, obstetrics, and surgery their skill and training permit. I talked with one family doctor, a gray-haired, bassoon-voiced man whose father was a family doctor before him, who not only does appendix, hernia, and gallbladder operations, but who helps instruct the interns in surgery. A hospital would be foolish to deprive itself of this man's ability because he's "just a G.P." [MORE ON 187]

Through its three-fold action in arthritis...relief of pain, improvement of function, and resolution of inflammation...BUTAZOLIDIN contributes significantly to the rehabilitation of the arthritic patient.

In addition to its marked therapeutic effectiveness, the advantages of BUTAZOLIDIN include:

Wide Scope of Usefulness—effective in the most crippling and chronic arthritides.

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Nonhormonal in Character—the therapeutic action of BUTAZOLIDIN is not mediated through the pituitary-adrenocortical axis.

BUTAZOLIDIN being a potent agent, the physician should carefully select candidates for treatment and promptly adjust dosage to the minimal individual requirement. Patients should be regularly examined during treatment, and the drug discontinued should side reactions develop.

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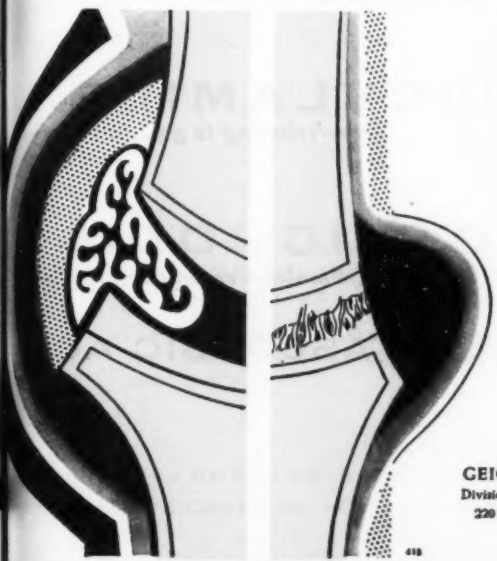
nonhormonal anti-arthritic

relieves pain • improves function • resolves inflammation



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Sodium-free,
potassium-free analgesic
for rheumatic diseases

ARTA

combines

SALICYLAMIDE
(*non-irritating to gastric mucosa*)

with

ORGANIC IODINE
(*stimulates resorptive processes*)

plus PABA *and* ASCORBIC ACID

Maintenance of high salicylate blood levels **without undesirable side effects** has long been a goal in the management of pain in rheumatoid arthritis, rheumatic fever, osteoarthritis, fibrositis and gout.

This goal has been achieved in *Artamide*. Through the use of salicylamide instead of one of the common salts or esters of salicylic acid, *Artamide* avoids gastric irritation. Coadministration of alkalizing agents is therefore unnecessary. In addition, *Artamide* is completely free of sodium and potassium—an important consideration for patients requiring restricted intake of these elements.

Artamide, too, is the first anti-rheumatic analgesic to employ the fibrolytic action of iodine to stimulate resorptive processes. Organic bonding of iodine in *Organidin* (Wampole) sheathes the destructive power of elemental iodine while preserving its therapeutic utility. The efficacy of *Artamide* is further enhanced by the potentiating effect of PABA and the compensating action of ascorbic acid.

AMIDE

WAMPOLE ®

COMPOSITION: Each white, coated *Artamide* tablet contains Salicylamide (0.25 Gm.), PABA (0.25 Gm.), Ascorbic Acid (20.0 mg.) and *Organidin* (10 mg.).

SUPPLIED: Bottles of 100 and 500. *Dosage:* Two tablets three or four times daily; in acute rheumatic fever, may be increased to two tablets hourly.

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In Neuritis—

is temporary relief enough?

Now—

THE LONG PERIOD OF DISTURBING SYMPTOMS CAN BE REDUCED BY THE PROMPT USE OF—

PROTAMIDE

When you have a case of neuritis (intercostal, facial or sciatic) where the inflammation of nerve roots is not caused by mechanical pressure, let Protamide demonstrate how much faster lasting relief can be obtained than with usual therapy.
Usual dose: one ampul every day for five days or longer.

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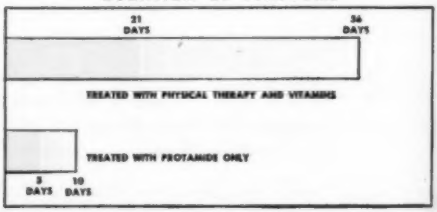
A COMPARISON BETWEEN COMPARABLE GROUPS WITH AND WITHOUT PROTAMIDE THERAPY

CONTROL—156 Patients
The Course of the Disease Was 21 Days to 56 Days

PROTAMIDE—84 Patients
Complete Relief was Obtained in 5 to 10 Days



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"TREATMENT OF NEURITIS WITH PROTAMIDE"
Richard T. Smith, M.D.
Associate in Medicine and Chief of Arthritis at Jefferson Medical College and Hospital; Associate Physician and Chief of Arthritis, Pennsylvania Hospital; Director of Department of Rheumatology, Benjamin Franklin Clinic.

REPRINTS AVAILABLE

Dr. Fount Richardson, of the University of Arkansas School of Medicine, reminded the public that once you're inside the building with the long corridors, "only the family doctor can protect you from the surgery-for-money specialist, the ghost surgeon, the fee splitter, and the gouger, or from the neglect of some condition outside your specialist's field."

Schools Are Helping

While the hospitals can limit the G.P.'s usefulness, it is the medical schools that more seriously influence the future of general practice.

The educators have done better by general practice than some of the hospital administrators. The University of Tennessee has a general-practice department in its medical school. The University of Kansas has a notable system to encourage men to practice family medicine in small towns. The University of Vermont, the University of Wisconsin, Tufts College, and some others have preceptor plans. Across the country, six of every ten medical-school seniors are proudly planning to become "just a family doctor."

At the University of Pennsylvania School of Medicine, they instituted what is called the Family Health Advisor Service, assigning first-year students to families they help care for the rest of their school days. Dr. John P. Hubbard, a tall, kindly, gray-haired professor of public health and preventive medicine, told me about it: "We want students to develop early that mysterious thing called the doctor-patient relationship. I recall my own training. It was two years before I saw a patient. Cadavers of men, yes. Pieces of men, yes. But not whole live men." The purpose of Pennsylvania's program was to get its students in touch with people, not to make G.P.s; but it is accomplishing both. There is now a General Practice Society among the students, with about a hundred future doctors meeting each month to hear experts discuss the G.P.'s work.

Student's Plans

I visited that towering citadel of healing, the medical center on New York's East Side, where Cornell University Medical College each year turns out about eighty-five superbly trained young M.D.s. I talked with several fourth-year students, earnest young men already dedicated to the medical ideal of service to mankind. Harry W. Daniell, of Millinocket, Maine, plans to be a family doctor in northern New England, working as part of a group of about five doctors. Theodore A. Collier, of New Canaan, Connecticut, intends to serve in the same area; he thinks a two-doctor team is preferable. Robert C. Patten, of Miami, expects to go to a small city in central Florida to practice solo—"the only way you can stay close to the family."

All three of these student doctors have participated in Cornell University's comprehensive medical-care

in chronic calcific tendinitis—

"unusually good results"[1]

"easy, safe, and free of side-reactions"[2]

"adaptable for routine office use"[3]

A 1-cc. injection of sustained-action MY-B-DEN, daily or every other day, relieved pain and disability in 44 out of 53 patients. In nine patients awaiting surgery, relief was "so gratifying" that operation was cancelled.[1] Equally successful results have been reported by other investigators.[2,3]

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Supplied: MY-B-DEN Sustained-Action in gelatine solution: 10 cc. vials in two strengths, 20 mg. per cc. and 100 mg. per cc. adenosine-5-monophosphate as the sodium salt.

1. Susinno, A. M., and Verdon, R. E.: J.A.M.A. *154*:239 (Jan. 16) 1954.
2. Rottino, A.: Journal Lancet *71*:237, 1951.
3. Pelner, L., and Waldman, S.: New York State J. Med. *52*:1774 (July 15) 1952.

"pioneers in adenylic acid therapy" **Bischoff**

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program. None of them wants to be the old-fashioned doctor. They expect to practice the most modern kind of medicine. They respect the specialists. But they are not overawed. One told me: "No specialty begins to compare with family practice for getting close to people. For the thrill of practicing this kind of medicine I'm willing to give up every other night and every other week-end for the rest of my life."

Life of a Rural G.P.

To see how the G.P. gets along in rural areas, I visited Connecticut. Dr. Ralph Jones (this is not his true name) is a general practitioner in Glastonbury, a town with 8,818 inhabitants.

Jones is a vigorous man of forty-two, with crew-cut grizzled hair that bristles and pale eyes under dark brows. Dr. Jones cares for about five hundred families in his fifty-five-square-mile town. He treats grownups and kids. He does emergency surgery and preventive medicine. He diagnoses their ills, except rare or obscure ones. He treats his patients in their homes, in the office portion of his white clapboard house, and in the handsome new hospital in Hartford. The one case in seven he personally cannot treat, he guides to the proper specialist. But he still watches over these patients, because they're his.

We got into his big, dusty sedan to talk while he made his rounds. Dr. Jones averages a dozen house visits a day. Week-ends he makes only imperative calls, but there are always two or three of them. Jones and another doctor cover for each other and care for each other's patients when either takes a week-end off.

House Call

We droned through Glastonbury, fifty-five miles an hour on the blacktop roads, sixty-five on the super highways, past a succession of choppy little hills, odd wood lots, and fields where the tobacco plants would soon be set out. We swung up a steep driveway to a farmhouse and stopped. An infant was crying. Dr. Jones grabbed his bag and was gone.

Later a young woman waved at us from a yard. "She had backaches," the doctor said as we passed. "I

"I said 'obese,' not 'a beast.'"

for your patients with hay fever

prescribe full enjoyment of summertime

CO-PYRONIL

(Pyrrobutamine Compound, Lilly)

'Co-Pyronil' usually produces:

RAPID RELIEF	frequently within fifteen to thirty minutes.
COMPLETE RELIEF	'Pyronil' is as much as twenty-five times as potent as other antihistaminic compounds.
PROLONGED RELIEF	b.i.d. dosage usually affords uninterrupted control.
FEW SIDE-EFFECTS	rarely causes sedation even on high dosage.

EACH PULVULE PROVIDES THE COMPLEMENTARY EFFECTS OF:

'Pyronil' (Pyrrobutamine, Lilly), 15 mg.

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(Cyclopentamine Hydrochloride, Lilly), 12.5 mg.

DOSE: 1 or 2 pulvules every eight to twelve hours.

ALSO: SUSPENSION CO-PYRONIL

Each 5-cc. teaspoonful is equivalent to one-half the above adult formula.

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strapped her back and showed her she was diapering the baby on too low a table. Cleared up in a week."

Hospital Calls

We rolled across the Connecticut River on the toll bridge and swept down the express highway to the Hartford Hospital. There was a patient to be discharged, dressed and waiting, tapping his foot.

Then the man who got his hand in a buzz saw. He was experiencing periods of depression following the accident. The surgeon at the hospital wanted him to see a psychiatrist. "No, I'll see Dr. Jones. He's my doctor." They talked together for fifteen minutes.

Downstairs to the orthopedic ward. A broken leg, complicated by diabetes. Healing would be a long process and, in a hospital, frighteningly expensive. Dr. Jones was helping the family arrange to move the man back to Glastonbury, under the care of a practical nurse.

Office Calls

We climbed back into the car and whirred onto the bridge that led back to Glastonbury. Half past one, more than two hours since we started out. Many people, many illnesses.

Mrs. Jones had lunch waiting but there wasn't much time to sit and talk. The doctor ate quickly, downed his coffee, pulled on his white jacket. There was a waiting room full of patients.

For all of them, the family doctor would never become obsolete. END

• "Intestinal flora can be changed either by administration of drugs or by modification of the diet."[1,2] Antibiotics, in particular, have been reported as markedly detrimental to a healthy intestinal flora and repeatedly as causative agents in diarrhea, acute ulcerative colitis, and inflammatory reactions involving the intestinal tract from the oral mucosa to the rectum.[3,4,5,6]

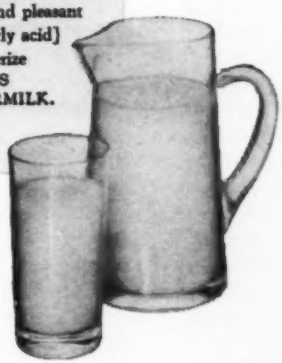
• "We found buttermilk preferable in infantile diarrhea, as compared with other milks."[7] Many researchers[8,9,10,11] concur in the opinion that acid milks such as buttermilk are an excellent source of healthy intestinal flora which promote normal digestion and elimination, especially in the presence of certain gastro-intestinal disturbances.

buttermilk therapy news

[1] J. A. M. A. 152:1676 [Aug. 22] 1953.
[2] J. A. M. A. 151:964 [Mar. 14] 1953.
[3] J. A. M. A. 152:585 [June 13] 1953.
[4] A. M. A. Arch. Int. Med. 90:677 [Nov.] 1952.
[5] J. A. M. A. 149:762 [June 21] 1952.
[6] A. M. A. Arch. Int. Med. 90:763 [Dec.] 1952.
[7] A. M. A. Am. J. Dis. Children 85:675 [June] 1953.
[8] A. M. A. Am. J. Dis. Children 84:757 [Dec.] 1952.
[9] Ann. Allergy 11:535 [Sept.-Oct.] 1953.
[10] New York State J. Med. 54:231 [Jan.] 1953.
[11] Med. Times 80:666 [Nov.] 1952.

• BORDEN'S BUTTERMILK is made by exacting standards with the same quality controls that are used in the processing of highly perishable fresh milk.

Careful choice of starter and critical culturing time contribute to uniformity and pleasant taste [not overly acid] that characterize BORDEN'S BUTTERMILK.



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News

Doctors get tax break • M.D. fights for penicillin patent • Illinois medical leader raps Administration • Medical veterans society grows • Urges Southern M.D.s to drop the color line • Legion takes its case to the doctor

Wants Quicker Answers From Medicine

Organized medicine too often answers its detractors "by the Pony Express method," says Dr. Martyn Schattyn of St. Louis. The doctors' replies, he explains, generally appear when the "false accusations and inferences" are already "cold" –and "where the laity will not even see them."

To overcome the delay, he suggests that the A.M.A. sponsor a daily or weekly news broadcast on a national hook-up. In this way, he writes in Missouri Medicine, the profession could present its side of the news and give "on-the-spot answers" to its critics.

State Aids School

A unique plan to raise building funds for a medical school through state taxation of natural-gas pipelines has been declared unconstitutional. But shortly after the U.S. Supreme Court made this ruling, Southwestern Medical School in Dallas got help from the Texas Legislature: Meeting in special session, the lawmakers appropriated $3,500,000 to meet the school's construction needs.

Enters Battle Over Salaried M.D.s

The campaign to outlaw hospital employment of doctors on salary has gained strength in one state: The Colorado medical society has announced its support of a demand by the state board of medical examiners that physicians so employed either quit or have their licenses revoked.

Under the state's medical practices act, physicians are forbidden to practice as "agents or employes of corporations." And the board of examiners contends that even the nonprofit hospital falls into this category. Adds the society, in support of this view: "The physicians of Colorado believe the present medical practices act is sound . . . As yet

OPPOSES SALARIED M.D.s in Colorado hospitals: Dr. George Buck maintains that they form a wedge for socialized medicine.

no evidence that the law fails to serve the public interest has come to our attention."

The state's hospitals have maintained that they'd be in serious trouble if they were to lose all salaried pathologists and radiologists. But the physicians answer that the continued employment of such specialists merely opens the doors for similar contracts between all medical men and corporations—and thus for the corporate practice of medicine.

"One Colorado hospital already has a salaried surgeon," comments Dr. George Buck, head of the board of examiners. "It's a question of whether we want to be socialized by the hospitals or by the Federal Government; and, frankly, most doctors I've talked to would prefer Federal socialization."

Home-Town Plan Cuts Veteran Care Costs

Many medical men have long suspected that the "home-town care" program for veterans saves the taxpayers considerable amounts of money—in addition to having other obvious advantages. Now, doctors in California have come up with some statistics that seem to back up this contention:

According to California Medicine, journal of the state medical society, the average visit to a V.A. out-patient department in California costs the U.S. Government $11.38. But under the home-town care program (which is administered by the California Physicians' Service) the cost per doctor visit averages only $5.90.

Concludes the journal: "If every veteran in California with a service-connected disability were treated by his family physician . . . there would be a direct saving of almost $700,000 a year to the Government."

Rise of Faith Healers Called Doctors' Fault

Advances in medical science and technical skill have resulted in an increasingly impersonal doctor-patient relationship. And this has led to a startling paradox: Modern med-

in serious infections

Chloromycetin®

(Chloramphenicol, Parke-Davis)

in bacterial infections, CHLOROMYCETIN is frequently effective against strains of gram-positive and gram-negative organisms resistant to other antibiotic agents. Notable clinical results have been observed in typhoid fever, bacterial pneumonia, and serious bacterial disorders.

in viral infections, marked clinical improvement, smooth convalescence, and an early return to normal activities may be anticipated following the administration of CHLOROMYCETIN. Striking clinical responses have been reported in viral pneumonia, psittacosis, and certain other serious conditions caused by large viruses.

in rickettsial infections, CHLOROMYCETIN often has a remarkable effect on the clinical course of the disease. Fever and toxemia associated with typhus, scrub typhus, and Rocky Mountain spotted fever may be dramatically controlled within 48 hours.

CHLOROMYCETIN is a potent therapeutic agent and, because certain blood dyscrasias have been associated with its administration, it should not be used indiscriminately or for minor infections. Furthermore, as with certain other drugs, adequate blood studies should be made when the patient requires prolonged or intermittent therapy.

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Grandpa too? Sure! VI-DAYLIN's a taste-treat at any age. It's all lemon-candy, golden-honey goodness—from the first suspicious sip to the last delicious lick. And each spoonful holds a full day's supply of *seven* important vitamins, including body-building B_{12}.

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For kids—and for grownups who dislike tablets or capsules—you'll find VI-DAYLIN tops among liquid multivitamins. Prescribe it in the economical pint-size bottle—there's more than enough for the next three months.

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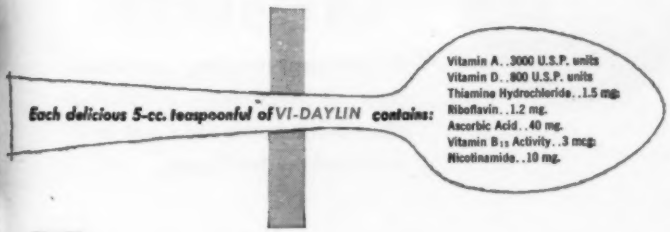

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icine is nourishing the growth of "faith healing," instead of stifling it. At any rate, that was the primary conclusion reached by the International Congress of Parapsychology at its latest meeting.

The forty scientists who attended the congress (which met in France) agreed that today's doctors too often fail to satisfy the average person's need for "a healing touch." One straw in the wind: an authoritative report that, in France itself, there are some 48,000 faith healers—as against only 42,000 licensed medical men.

Most delegates to the congress were skeptical about the cultists' methods; but few disputed such statements as this one (from Dutch psychologist David van Lennep): "When [patients] go to a regular doctor, they are just put into a medicine factory."

The remarks of Jesuit Father Louis Beirnaert, a practicing psychoanalyst, hit home even harder: "We have spent too much time criticizing healers because they are not doctors and not enough time criticizing doctors who are not healers."

Doctors Get Tax Break

The recent trend toward levying additional local and state taxes on physicians has been halted in one area: The Arizona Legislature has ruled that professional men will *not* have to pay a 2 per cent "privilege"

tax on their gross earnings. Something over a year ago, the State Tax Commission had ordered such a tax to be paid by all businesses, even though income came from "sale of services" rather than of goods.

Arizona doctors and other interested groups took their case to the state Supreme Court. But the issue has now been decided by the Legislature. The major point of their clarifying amendment to the "privilege tax" law: "The tax levied by this section shall not apply to . . . gross income from . . . occupations or businesses which involve sales or transfers of tangible personal property only as inconsequential elements thereof."

M.D. Faces Long Fight For Patent Rights

The physician who claims to have invented procaine-penicillin is having a tough time establishing his exclusive right to its manufacture. After a nine-year battle, Dr. Simon L. Ruskin of New York City was recently awarded a patent for the drug. But the matter is far from settled.

Dr. Ruskin has now filed suit against a pharmaceutical manufacturer who holds another patent under which much of the nation's procaine-penicillin is currently produced. But he's faced with a countersuit, charging that the preparation had been in "public use" more than a year before he filed his original patent application. [MORE→

The Calendar Holds the Key...

In tension-anxiety states, consider premenstrual tension . . . when cramps, leg pains, nausea, irritability, insomnia, and edema appear regularly before menstruation. Evidence shows these symptoms are due to excess fluid balance—effectively reduced in 82% of cases with M-Minus 5.[1]

1. Vainder, M.: Indus. M. & S., 22:183

M-Minus 5®

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Acetophenetidin..... 100 mg.

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dilates both arterioles and capillaries

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The litigation appears likely to drag on for years. But the stake is considerable: Drug manufacturers estimate that they've sold $250 million worth of procaine-penicillin during the past four years.

Illinois Medical Leader Raps Administration

Says it's aiding the cause of socialized medicine

Have doctors lost confidence in the Eisenhower administration? The 1953-54 president of the Illinois State Medical Society believes they have—or should have. "Two years ago," says Dr. Willis I. Lewis, "the medical profession as a whole probably reflected the viewpoint of the doctor who said, 'Now I can forget politics and get back to the practice of medicine.'"

But the Administration hasn't made good on its promise to free the country's practitioners from the threat of socialization, charges the Illinois physician. Instead, "No sooner had the new Administration taken over in Washington than the President announced he was creating a Department of Health, Education, and Welfare . . . headed by a New Dealer from Texas."

Many "dismayed" doctors can't

IN PATENT FIGHT: Dr. Simon L. Ruskin is attempting to obtain exclusive rights to the manufacture of procaine-penicillin.

FREE MEDICINE SUFFERS under the present Administration's program, charges Dr. Willis I. Lewis, himself a Republican.

help remembering their past battles against "repeated efforts . . . to set up such a department," adds Dr. Lewis. And to make it worse, he complains, "the medical profession was not accorded even a medical undersecretaryship. We wound up with a figurehead representative . . . in the role of special assistant for health and medical affairs."

Also high on his list of charges against the current Administration:

¶ It has pressed for the compulsory inclusion of doctors under the Social Security law.

¶ It has advocated a Federal reinsurance program.

¶ It has sponsored a plan whereby doctors would certify totally disabled persons for maximum benefits under the old age pension plan.

All those proposals, maintains Dr. Lewis, indicate a tendency toward "creeping socialism" that medical men didn't expect from a Republican administration.

M.D.s Prefer Women?

"Most doctors prefer to treat women rather than men," according to newspaper columnist Hal Boyle. The alleged reason: "Women . . . are more sensible—at least about their ailments. A woman accepts illness as part of life," but the average man "feels his body has betrayed him" when he gets sick.

To pin down this generalization, the columnist quotes the statement

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**Hensel, H. A. Postgrad. Med. 8:293, 1950.*

More Than Half a Century of Service to the Medical Profession

of an unidentified physician: "Women are willing to wait until tomorrow to be cured. But men always want to be cured yesterday."

Compulsory Health Plan Deemed a Failure

India's two-year-old experiment with a compulsory health insurance plan for workers appears to be bogging down. According to an editorial in Caravan, a New Delhi monthly, doctors and patients alike are dissatisfied with the program.

The physicians are complaining because they get only four rupees of the seventy supposedly set aside for the care of each patient. So most of them apparently refuse to cooperate; and those who do, says the writer, give only "superficial" attention to their patients.

As a result, many Indian workers (who contribute to the Government-sponsored insurance fund) feel they are not getting their money's worth. But, the editorial adds, their unions are in a dilemma: They have supported the program so enthusiastically that they don't dare oppose it openly—even though their own members are suffering under it.

Veterans Society Grows

If you're a veteran, you can now join the National Medical Veterans Society even though your community has no local chapter. The soci-

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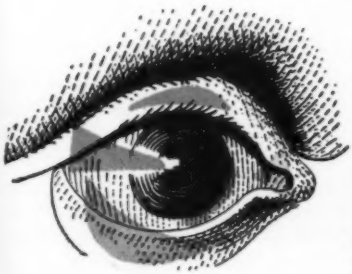
Brand of **tetracycline**

new ophthalmic ointment

Now ***sensitive ocular infections can be treated with this*** *newest* ***dosage form of the*** *newest* ***broad-spectrum antibiotic . . .***



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Tetracyn Ointment (topical) 30 mg./gram, ½ oz. and 1 oz. tubes

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ety has amended its constitution to permit individuals to join as members-at-large.

Officials of the organization have announced that they'll of course continue to encourage the formation of local chapters wherever possible; but they hope to double their present membership of 20,000 simply by reaching out for the unaffiliated doctor.

Spine Men Conduct Their Own Polio Drive

The nation's chiropractors have now come up with a polio prevention program all their own. Its aim: to prove that medical science has no monopoly on ways to check the disease. One cultist, speaking at a recent convention of the Colorado Chiropractic Association, dismissed the Salk vaccine in few words: "We think there are other means of preventing polio."

To translate this conviction into action, the chiropractors have launched their campaign with all the customary fanfare. One offer: free chiropractic adjustments (aimed at forestalling polio) to any child who wants them.

A Free Chest X-Ray With Every Pack?

Cigarette smokers needn't renounce their favorite weed because of the controversy over lung cancer. Dr. Ralph Gancher of Oakland, Calif., says he has a better idea—"a plan

" . . . and be sure she takes her VITAMINS!"

Gastrointestinal disorders interfere with vitamin intake and absorption through anorexia, nausea, vomiting, and hypermotility. Therapeutic diets may further limit intake. Adequate vitamin supplementation offers dependable protection against the development of avitaminoses.

MERCK & CO., INC., RAHWAY, N.J.—as a pioneer manufacturer of Vitamins—serves the Medical Profession through the Pharmaceutical Industry.

that will enable us to solve our problem as we go on smoking."

In an article appropriately called "Cancer, Schmancer," he proposes that cigarette buyers be given premium coupons with each purchase. The coupons would entitle the happy smoker to diagnostic tests and treatments ranging all the way from a minifilm of the chest (with each pack) to "a lobectomy or pneumonectomy and three glorious weeks in a hospital" (with every hundred cartons).

But what of the smokers "who don't get cancer but just cancerophobia"? Well, says Dr. Gancher, in his county medical association bulletin, such persons should be entitled to "the grand prize of twenty-four months of psychoanalysis on a genuine Simmons Beautyrest Mattress."

Urges Southern Doctors To Drop Color Line

Latest evidence that color bars in the medical profession are breaking down: The official organ of a Southern state medical society has raised its voice editorially for acceptance of Negro doctors in the association.

Says the North Carolina Medical Journal: "There is little doubt but that the majority of our members recognize the justice of allowing Negro physicians to share in the opportunities of keeping up with medical advances that membership . . . affords." The journal concedes that "the feasibility of including Negro members in . . . social func-

tions" is at present "debatable"; but it sees no reason for further exclusion of "our colored colleagues" from scientific—and possibly business—meetings.

Concludes the journal: "Our society could observe its hundredth birthday in no better way than by proving that it is mature enough to embrace men of all colors and creeds."

Legion Takes Its Case To the Doctor

The American Legion is now distributing among the nation's physicians a booklet entitled "Veterans Hospitalization." Ostensibly, it's designed "to guide you in your advice to your veteran patients." Actually, it's mainly concerned with neutralizing A.M.A. opposition to free medical care for non-service-connected cases.

The booklet is largely a digest of old Legion arguments. In one section, for example, it drives home the familiar contention that "the veteran remains a distinct class"—and is therefore entitled to all the free medical benefits he can get. But the A.M.A., says the Legion, takes the position "that a veteran . . . is now only an ordinary citizen who has done his duty."

"What has medicine to gain by such a puerile attitude?" asks the pamphlet. "What affair is it of medicine anyway? . . . Opposition from medicine will bring nothing but criticism to the A.M.A."

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works throughout hepato-intestinal system

FORMULA: Each tablet contains Bile Salts 1.07 gr., Ext. Cascara Sag. 1.00 gr., Phenolphthalein 0.50 gr., Oleoresin Capsicum 0.05 min.

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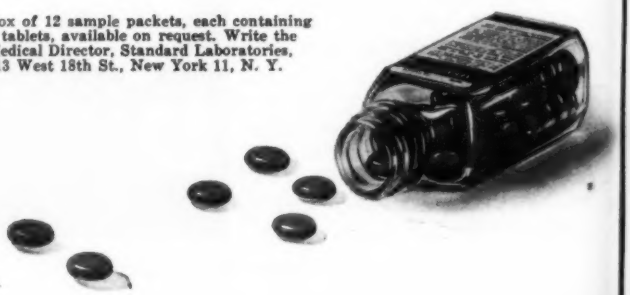
COLON—Veracolate has a mild yet dependable laxative effect. Dosage (1 tablet t.i.d. or 2 tablets at bedtime) can be readily adjusted to suit each patient. 4

Box of 12 sample packets, each containing 6 tablets, available on request. Write the Medical Director, Standard Laboratories, 113 West 18th St., New York 11, N. Y.



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While Peritrate has been found effective in reducing the number of attacks in almost 80 per cent of patients,[2] comparison with nitroglycerin disclosed that Peritrate exerted ". . . a marked modifying influence on the electrocardiographic response to standard exercise . . . comparable to [results] obtained with glyceryl trinitrate."[1] Unlike glyceryl trinitrate, this "*improved response could be elicited as long as four to five hours after administration of the drug.*"[1]

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Together with significant improvement in the EKG,[1,2] Peritrate prophylaxis will reduce the nitroglycerin need in most angina pectoris patients.[3] A continuing schedule of only 1 or 2 tablets 4 times daily will usually

1. *reduce the number of attacks in almost 80 per cent of patients*[2]
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Available in 10 mg. tablets in bottles of 100, 500 and 5000.

1. Russek, H. I.; Urbach, K. F.; Doerner, A. A., and Zohman, B. L.: J.A.M.A. *153*:207 (Sept. 19) 1953.
2. Humphreys, P., *et al.*: Angiology 3:1 (Feb.) 1952.
3. Plotz, M.: New York State J. Med. *52*:2012 (Aug. 15) 1952.

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INDEX OF ADVERTISERS

Memo

FROM THE PUBLISHER

Service: the Key

One of the country's most knowledgeable general magazine publishers was my guest at luncheon recently. This man has produced magazines devoted to fiction, sports, movies, adventure, news, and general interest material of almost every type.

"I thought you'd be interested to know," he announced over coffee, "that I'm giving up my general magazine connections next month and entering the business magazine field."

"I *am* interested," I replied. "But why the switch?"

"Well," he said, "the handwriting on the wall has been getting clearer all the time: The general magazines, with some major exceptions, face a steadily shrinking market for what they have to offer."

"I'm inclined to agree," I said. "But what's your explanation?"

"Just one thing," he replied: "Sharper competition for the reader's time. More and more of that time is now being swallowed up by the average man's work, by his new diversions (TV, for example), and by the business of merely living in today's complex society.

"And how does he compensate for it? Naturally, by cutting down on activities he might enjoy but can do without—such as recreational reading in general periodicals."

"And what about the business magazines?" I asked.

"They're in a different category," he said. "People *have* to read them to get ahead in the world.

"The business magazines give *service*. They're a *necessity*. So much so that *they*, in my view, can properly be called the 'magazines of tomorrow.'"

I couldn't help feeling that my guest might have overstated the case a bit. But I heard some statistics the following week that strongly supported what he'd said.

The figures were included in a report given at the annual meeting of the country's largest business magazine association: National Business Publications. They had to do with that traditional barometer of magazine success or failure: advertising revenue.

Back in 1924 (when MEDICAL ECONOMICS was just a year old), the report stated, advertising in the relatively few business magazines then published totaled only about $25 million a year. The Saturday Evening Post alone, in 1924, carried almost twice as much advertising as did all the business magazines of that year combined.

But the next three decades brought a radical change: By the beginning of 1954, American in-

Publisher's Memo

[CONTINUED FROM 223]

dustry's investment in business magazine advertising had soared to $400 million a year.

That $400 million is more than triple the amount now spent on advertising in all general monthly magazines. It even exceeds—by a substantial margin—the current advertising revenue of The Saturday Evening Post and of all other general weeklies put together.

These facts concern the average business or professional man chiefly because they show the growing vitality of the business magazines he has come to depend on.

The vote of confidence given these magazines by their readers and advertisers is both an encouragement and a challenge.

MEDICAL ECONOMICS, for one, intends to meet that challenge by bettering its service in every possible way. —LANSING CHAPMAN

[Mr. Chapman was the first president of National Business Publications. At the 1954 conference to which he refers, the organization awarded him its Silver Scroll "for outstanding business press leadership beyond the call of office."—ED.]

PHOTOGRAPH BY CHARLES KERLEE

He'll skip dessert and like it, too—with

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Most overweight patients need your help to pass up such rich foods—and still be content.

ALTEPOSE provides *triple* action in obesity—curbs the appetite, controls nervous tension, helps convert excess fat into energy.

Quick Information: A practical adjunct to low calorie diets, each ALTEPOSE tablet provides 50 mg. 'Propadrine,' 40 mg. thyroid and 25 mg. Delvinal®. The usual dose is one tablet taken two or three times a day, one-half to one hour before meals.

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No. 3: "Instructions for Bathing Your Baby."
No. 4: "The Hygiene of Pregnancy."
No. 5: "Home Care of the Bedfast Patient."
No. 6: "Sick Room Precautions to Prevent the Spread of Communicable Disease."